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ABSTRACT

"Zero to Three" is a single-focus bulletin of the National Center for Infants, Toddlers, and Families providing insight from multiple disciplines on the development of infants, toddlers, and their families. Compiling articles from participants of the Leadership Development Initiative Class of 2001-2002, this issue focuses on evaluation of infant-family programs. The articles are as follows: (1) "Evaluating Programs that Serve Infants and Families: The Quest for Quality" (Virginia Buysse and Lisa Boyce); (2) "Evaluating Early Childhood Programs: Improving Quality and Informing Policy" (Walter S. Gilliam and Valerie Leiter); (3) "Enhancing the Quality of Relationships in Infant-Toddler Child Care: A Developmental Process" (Mimi A. Graham, Anne E. Hogan, Barbara A. White, and Christine A. Chiricos); (4) "Project Connect: Seeing the Forest and the Trees" (Gambi White-Tennant); (5) "Incorporating Principles of Family-Centered Practice in Early Intervention Program Evaluation" (Lauri S. Dinnebeil and Lynette M. Hale); (6) "Collaborative Program Evaluation: Hawaii's Experience with Early Intervention Services" (Taletha M. Derrington and Beppie J. Shapiro); (7) "Parents Keep Our Eyes on the Prize: Monitoring Early Intervention in Massachusetts" (Ron Benham, Patti Fougere, Faith Piaggi, and Katharine Thomas); (8) "California's Proposition 10 and Local Evaluation: A County-Level Report from the Field" (Marc R. Thibault, Pablo A. Stansbery, and Linda A. Wollesen); (9) "Every Child Counts: Creating a Community Holding Environment for Families with Young Children" (Deborah A. Bremond and Teddy Miller); (10) "Evaluating the Impact of Infant and Early Childhood Mental Health Training on Community Agencies" (Mary Claire Heffron); (11) "From Program Evaluation to Persuasive Reports" (Sandra Smith and Judith Brown Clark); and (12) "Evidence-Based Program Evaluation: A Guide for Agencies to

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Self-Assess Their Practices and Policies" (Diana Hammon Kellegrew, Susan O'Brien, and Elaine Groppenbacher). The issue includes an additional point-of-view article, "Early Head Start--An Investment in our Youngest Citizens" by U.S. Senator Tom Harkin. Regular departments of the bulletin list Zero to Three publications, videotapes, and on-line resources. (HTH)

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July 2003
Volume 23 No. 6

Journal of ZERO TO THREE: National Center for Infants, Toddlers, and Families

Evaluating Infant–Family Programs

Answering the Question, "Does the Intervention Work?"

The Logic of Logic Models

Involving Families in Program Evaluation

Evaluation on a Shoestring

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Editor's Note

It is the tradition in some institutions for the graduating class to put on a play. In others, the class takes a trip. At ZERO TO THREE, Solnit and Harris Fellows in the Leadership Development Initiative (LDI) are establishing their own class tradition — the conceptualization and production of an issue of *Zero to Three* on a topic of special concern to the class.

The LDI Class of 1999–2000 wrote about the many ways that infant–family practitioners can shape public policy that affects infants, toddlers, and families (*Zero to Three*, June/July, 2001). The LDI Class of 2001–2002 decided to focus on the evaluation of infant–family programs. The result is the issue of *Zero to Three* that you are about to read.

Because the LDI works hard to recruit outstanding Fellows from all sectors of the infant–family field, perhaps I should not have been surprised to discover that the 2001–2002 LDI class includes:

- university faculty who teach program evaluation to graduate students,
- researchers who have developed instruments for evaluating program quality and participant outcomes,
- program directors who must make sure that evaluations are meaningful to front-line staff, managers, and funders,
- state agency administrators who rely on program evaluation data to make policy decisions, and
- consultants who assist infant–family program staff on aspects of program evaluation that range from the construction of a logic model to effective reporting of evaluation results.

In fact, program evaluation expertise in the class is so abundant that the Guest Editors, Harris Fellow **Virginia Buysse** and Solnit Fellow **Lisa Boyce**, were able to ask authors to team up to address some particularly challenging issues. The process of drafting, critiquing, and revising contributions (with *Zero to Three*'s multidisciplinary readership in mind) was educational for everyone — especially me. The product of this effort is an extraordinarily rich, diverse and "grounded" issue — a true gift to the infant–family field. A *class* gift, one might say.

Emily Fenichel

Developmental Milestone

State Early Childhood Policy Leadership Forum Fellows for 2003-2004

The State Early Childhood Policy Leadership Forum is a joint initiative of the ZERO TO THREE Policy Center and the National Governors Association Center for Best Practices, supported by the John D. and Catherine T. MacArthur Foundation. The Forum has selected 11 pioneers in early childhood state policy for the 2003-2004 class: Esther Buch (Michigan); Carolyn T. Cobb (North Carolina); Bethany J. Geldmaker (Virginia); Linda W. Hampton (Alabama); Janie L. Huddleston (Arkansas); Irene S. Jacobs (Arizona); Donna C. Middleton (Oregon); Marsha H. Moore (Georgia); Debbykay J. Peterson (Minnesota); Susan W. Sonnier (Louisiana); and Susan Wilson (Connecticut).

Forum Fellows are individuals who are actively guiding statewide comprehensive birth-5 system initiatives. The Forum provides recognition for their work, an opportunity to enhance their leadership skills, and a network of peers and national experts to draw on as they develop new strategies for systems change.

ZERO TO THREE

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Customer Service: 1-800-899-4301
www.zerotothree.org

CONTENTS

July 2003
Volume 23 No. 6

Features

Evaluating Programs That Serve Infants and Families: The Quest for Quality — *Virginia Buysse and Lisa Boyce* 4

Evaluating Early Childhood Programs: Improving Quality and Informing Policy — *Walter S. Gilliam and Valerie Leiter* 6

Enhancing the Quality of Relationships in Infant–Toddler Child Care: A Developmental Process — *Mimi A. Graham, Anne E. Hogan, Barbara A. White, and Christine A. Chiricos* 14

Project Connect: Seeing the Forest and the Trees — *Gambi White-Tennant* 21

Incorporating Principles of Family-Centered Practice in Early Intervention Program Evaluation — *Laurie S. Dinnebeil and Lynette M. Hale* 24

Collaborative Program Evaluation: Hawai'i's Experience With Early Intervention Services — *Taletha M. Derrington and Beppie J. Shapiro* 28

Parents Keep Our Eyes on the Prize: Monitoring Early Intervention in Massachusetts — *Ron Benham, Patti Fougere, Faith Piaggi, and Katharine Thomas* 33

California's Proposition 10 and Local Evaluation: A County-Level Report From the Field — *Marc R. Thibault, Pablo A. Stansbery and Linda A. Wollesen* 35

Every Child Counts: Creating a Community Holding Environment for Families With Young Children — *Deborrah A. Bremond and Teddy Miller* 40

Evaluating the Impact of Infant and Early Childhood Mental Health Training on Community Agencies — *Mary Claire Heffron* . . 47

From Program Evaluation to Persuasive Reports — *Sandra Smith and Judith Brown Clark* 51

Evidence-Based Program Evaluation: A Guide for Agencies to Self-Assess Their Practices and Policies — *Diane Hammon Kellegrew, Susan O'Brien, and Elaine Groppenbacher* 53

PAGE 21

PAGE 35

Departments

Point of View 60

Publications 61

Online Resources 62

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Evaluating Programs That Serve Infants and Families:

The Quest for Quality

Virginia Buysse
Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill
and
Lisa Boyce
Early Intervention Research Institute, Utah State University

Why would a program serving young children and families invest limited resources in ways to evaluate its services? Renewed interest in program evaluation is fueled in part by the now-familiar demands for quality and accountability in human services, as well as the more recent call from policymakers and researchers to adopt evidence-based practices.

As administrators and professionals in community programs, we are also motivated by a genuine desire to understand how our work affects young children, families, and the programs that serve them. At a time when additional resources to maintain even basic services (much less create innovations or evaluate them) are scarce, we seek information that will help them make wise decisions about how to improve the quality of the services we offer. Program evaluation is a worthwhile investment when information obtained through systematic data collection leads to more effective ways of identifying children and families who need services or of designing interventions that are more acceptable and effective.

In this issue, we feature a variety of approaches to conducting program evaluations that range from a small-scale evaluation of a single program component to a statewide evaluation of Child Find efforts as part of one state's early intervention system. Collectively, the articles illuminate the process of an effective evaluation, including steps for getting started, methods of involving families and key stakeholders, and ways of using the findings to inform program and policy decisions.

The lead article by Walter Gilliam and Valerie Leiter sets the stage by offering a framework to guide program evaluation efforts within the infant–family and related fields. The authors illustrate how a program can build a logic model to link program services and outcomes.

Diane Kellegrew and her colleagues, Elaine Groppenbacher and Susan O'Brien, offer a contrasting evaluation framework for "busy administrators" that builds on reflective practice principles. They share their notions of program evaluation as "a recursive process" that mirrors the way professionals plan, implement, and evaluate interventions for children and families.

Other articles in this issue present some of the challenges and opportunities associated with program evaluation in child care, infant mental health, Part C early intervention, Early Head Start, and hospital settings. Mimi Graham and coauthors and Mary Claire Heffron provide examples of programs overcoming limited resources of time, funding, and expertise to balance their responsibilities to implement best practice with the need to evaluate these practices in order to improve them. Taletha Derrington and Beppie

PHOTO: ROBERT MAUST

Shapiro, and Deborrah Bremond and Teddy Milder illustrate how stakeholders can work together to build on existing questions and identify program needs to design and implement evaluations. Many of the articles in this issue highlight strategies for practitioners to obtain feedback about their work and answer questions about what is working well and who seems to be benefiting the most. Gambi White-Tennant provides an example of the flexibility that is sometimes needed in embarking on evaluation efforts in order to improve programs.

Finding suitable measures is an ongoing challenge. Measures for some outcomes do not exist or cannot be implemented with limited resources. In addition to providing a look at an evaluation of Proposition 10 efforts in one county in California, Marc Thibault, Pablo Stansbery, and Linda Wollesen introduce a measure to assess parent and child outcomes of a home visiting program.

Families are often overlooked as a resource. Laurie Dinnebiel and Lynette Hale provide a framework and rationale for involving families in the evaluation process while Ron Benham and coauthors provide an example of how families are involved in evaluating and improving Part C early intervention programs in Massachusetts.

These articles, taken as a whole, present the efforts of dedicated practitioners, administrators, and researchers to overcome the many barriers to evaluation and take advantage of opportunities and resources as they assess and improve programs for young children and their families.

Finally, Sandra Smith and Judith Brown Clark offer concrete suggestions for writing reports about evaluation findings in ways that engage readers and motivate them to use the results to improve their services, enhance their professional development efforts, or advocate for children and families. It is important to consider dissemination activities at the beginning of the planning process. Program evaluation planners should ask themselves several questions: Who will be interested in the findings of our evaluation? What is the best way to reach them? How can the findings influence public policy? Perhaps one day, empirical findings from carefully planned and executed evaluations will serve not only as the impetus to improve community programs, but also as another source of professional knowledge to advance the field and improve services and outcomes for all young children and families.

Evaluating Early Childhood Programs:

Improving Quality and Informing Policy

Walter S. Gilliam
Yale University Child Study Center, New Haven, Connecticut
and
Valerie Leiter
Simmons College, Boston

These are exciting yet challenging times for programs that provide early intervention, care, and education to young children and families. We know more now than ever before about the importance of early intervention and education services for young children. We know that these programs, when delivered at the appropriate levels of quantity and quality, have meaningful and lasting positive impacts for children and families, and we are continually learning more about which types of services are most effective for which families and young children.

The federal Government Performance and Results Act of 1993 heralded a new era of accountability for public-funded programs, mandating evidence of effectiveness for programs and services funded through public money. Not long after that, many private foundations echoed this demand for accountability. Evidence of program quality and effectiveness are of paramount importance in convincing funders to continue investing in programs, whether those funders are public or private. This article provides some guidance to professionals in the field of infant–family programs and early childhood care and education who wish to begin the process of evaluation.

What Is Program Evaluation?

Program evaluation is a systematic process of describing the components and outcomes of an organized intervention or service, with the aim at improving the quality of the services received or documenting the program's beneficial impacts. Evaluations, like the programs and participants themselves, can take many forms, ranging from careful yet relatively straightforward descriptions of the quantity and quality of the services provided to elaborate and rigorous studies of the effectiveness of those services. Of course, the more rigorous the evaluative methods, the more confidence one can have that any observed beneficial outcomes were actually caused by participation in the program.

Reasons to Conduct a Program Evaluation

Program implementers are typically quite busy with the day-to-day operations of their program. There are several reasons why such busy people might choose to voluntarily

at a glance

- The question "Does it work?" lies at the crux of all program evaluation.
- The 1993 Government Performance and Results Act began an era of accountability by mandating evidence of effectiveness for publicly funded programs.
- Evaluation studies may include process studies, outcome or impact studies, and cost–benefit analyses.
- The particular goals of the evaluation should help drive which aspect of the evaluation is stressed.
- A logic model is an essential part of any program evaluation.

make their lives, and the lives of those around them, even busier by embarking on a process of self-evaluation. These reasons might include the desire to embark on a process of continuous quality improvement, to implement monitoring systems across program sites, to secure additional funding, to protect existing financial resources, or to advocate for changes that would better align policy with program objectives. In some cases, the program evaluation might be mandated by the program funders or authorizing agency, who want to see evidence that your program "works."

How complicated can a three-word sentence be? The question "Does it work?" lies at the crux of all program evaluations.

Does It Work?

How complicated can a three-word sentence be? The question "Does it work?" lies at the crux of all program evaluations.

Defining "It"

All efforts toward program evaluation should begin with a serious consideration of what constitutes the intervention itself. What are the components of the intervention, and are they all necessary? Simply defining the core elements of the intervention can be an enlightening exercise. These programmatic inputs, or aspects of the program that are assumed to lead to the desired outcomes, are the focus of a process or formative evaluation. After you define the various "ingredients" of the program, your attention may turn to issues of appropriate quantity and quality. Program quantity is often an issue of both intensity and duration. How frequently and for how long must children and families participate in the program before they can be considered to have been provided an adequate "dose?" Measuring intensity and duration takes into account issues of participant drop-out, regularity of contact, and treatment compliance (the degree to which participants actively participate in the services). In some ways, these issues can be thought of as both program inputs and outcomes, because participation rates may be a function of the degree to which participants are willing and able to participate in the service. Measurement of program quantity is rather straightforward for many programs, because these data are often collected for financial reimbursement or program monitoring.

Program quality can be far more involved to measure. The quality of the program might include things like the quality of the relationship between the professional and the family, the degree to which professionals faithfully follow the program's particular methods for assessing and serving children and families, the accuracy of needs assessments or other clinical evaluation methods, and other issues having to do with the quality of the service as it is being experienced by the participants. Monitoring professionals' appropriate administration of the program or service requires a clear statement of what the services should look like, when implemented appropriately. This is often accomplished through a treatment or service manual that clearly states the roles of all professionals in the program and what appropriate services might look like when observed by another. The development of a manual of services can be an important early step in useful program evaluation. (Materials on the Parents As Teachers Program [Wagner, 1998] is a useful example of how detailed a service manual may be.)

Finally, for some program types, valid measures of what the services should look like already exist and are used routinely in program evaluation. Most notably, early childhood care and education programs frequently use instruments such as the Infant–Toddler Environment Rating Scale—Revised Edition (ITERS-R; Harms, Cryer, & Clifford, 2003), the Early Childhood Environment Rating Scale—Revised Edition (ECERS-R; Harms, Clifford, & Cryer, 1998) and the Caregiver Interaction Scale (Arnett, 1989) to assess how well their program matches service ideals that have been supported through previous research.

Before or while you define the program or service, it must be placed in the context of population and community for which it is designed. This might involve both a needs assessment of the population to be served and a community inputs assessment. The needs assessment focuses on determining to what degree the program addresses a real need in the community. For example, if your program's primary goal is to prevent reported cases of child abuse, it would be useful to know what the prevalence of abuse reports is within the program's area, what demographic of children and families are the most likely subject of these reports, and what age ranges are most common. These data could help make certain that the program focuses on the families and children most likely to benefit. It is also important to understand the coverage of other programs in the community that also seek to prevent child abuse. If there is a large saturation of other programs that have the same goal as your program, then it may be difficult to demonstrate that your program added value at the community level.

Defining "Work"

Equally important in the program-to-outcomes equation is defining the desired outcomes of the intervention, and how those outcomes might be measured. In most cases where it is important to demonstrate effects, it is best to focus the program's service efforts on achieving a small number of well-selected outcomes. When desired outcomes are too numerous, the program risks spreading its effects so thinly over a variety of potential outcomes that none are achieved to a detectable degree (Gilliam, Ripple, Zigler, & Leiter, 2000). Likewise, desired outcomes should

be attainable. Outcomes that are too ambitious might not be achieved during the span of the intervention. Successful program evaluations often limit the number of final outcomes being sought, and instead focus on the many intermediate outcomes in the desired chain of effects. This idea will be discussed further when we introduce the topic of a logic model.

The Components of Evaluation Studies

There are three components to evaluation research: process studies, outcome or impact studies, and cost–benefit analyses. Evaluation studies may include any of these three components, either alone or in combination. (See Table 1 for a glossary of key evaluation concepts, and Table 2 for an evaluation checklist.)

Process Study

The overall goal of the process study is to understand exactly what a program did—documenting the program's operations. Typically, a process study, also referred to as a formative evaluation, measures the scope and intensity of the program's intervention: What kinds of services did participants receive? How often did they receive services? What was the staff-to-participant ratio? How long did participants stay in the program? When and why did participants drop out? The specific goals of a process study may vary, depending upon its purpose. Process studies may be performed to identify which parts of a program work well and which parts need improvement. They may also be performed to find out if a program is being implemented consistently with the way that it was planned. And they may be carried out as part of a larger evaluation study, so that when the effects of the program are measured, it is clear exactly what produced those effects.

The process study is an essential early step in any program evaluation. Indeed, it is the process study that determines which aspects of the program are being fully implemented and ready to be evaluated (see White-Tennant, this issue, p.21). Any disappointing findings discovered during a process evaluation should be addressed by improving the program services before making any attempt to evaluate program outcomes or impacts (Gilliam, 2000).

Table 1: Glossary of Key Evaluation Concepts

Comparison group designs: A less rigorous alternative to random assignment studies in which participants are compared to non-participants who are similar in terms of key demographic features.

Cost–benefit study: A process of examining the operating costs of a program, relative to the benefits achieved. Total costs calculated and divided by the number of "units" served through the program, resulting in a cost–benefit ratio that indicates how much it cost to achieve each outcome(s) produced.

Inputs: The program's "key ingredients," aspects of the program's quantity and quality that are believed to lead to the program's desired outcomes for participants.

Impact study: A scientifically rigorous, quantitative way of measuring program effects that seeks to demonstrate a causal relationship between participation in the intervention and the desired outcomes, and does so by comparing outcomes for program participants with the same outcomes experienced by comparison or control groups that did not receive the program intervention.

Logic model: A clear and logical explanation of how the various components of a program or service effect the changes in the participating children and families that move them toward the desired programmatic outcomes.

Needs assessment: An evaluation of the service needs of the population that the program seeks to serve.

Outcomes: How children, families, or both who participated in the program look at the end of the program or intervention on key variables of interest to program professionals.

Outcome study: A systematic, quantitative assessment of how participant children and families look on key outcomes at the end of the program.

Pretest comparison designs: A less rigorous alternative to both random assignment and comparison group designs, where participants' outcomes at the end of the program are compared to their own starting condition prior to the beginning of their participation in the intervention.

Process study: A systematic effort to understand exactly what a program did (documenting the program's operations), usually involving both qualitative and quantitative data to measure the scope and intensity of the program's intervention.

Program evaluation: A systematic process of describing the components and outcomes of an organized intervention or service, with the aim of improving the quality of the services received or documenting the program's beneficial impacts.

Qualitative data: Data that are not measured numerically, but rather are described verbally.

Quantitative data: Data that are measured numerically.

Random assignment studies: A rigorous form of impact study where program participants are randomly selected from a pool of potential participants and are then later compared to those who were not selected to participate in order to determine the effects of the program.

Outcome–Impact Studies

Outcome studies and impact studies are two approaches to measuring a program's effects. Sometimes people use the terms *outcome* and *impact* interchangeably, but there are important technical differences between them. Program *outcomes* include all of the things that the program hopes will change for the better in the participants and their lives — in other words, the degree to which participants are able to achieve the conditions that the program seeks to facilitate. Depending on the nature of the program, outcomes might include such things as the percentage of families that obtain adequate and stable housing, the percentage of parents who report decreased levels of parental stress, or the average social or language development of the participant children. Studies that demonstrate program *impacts* go one step further. They attempt to measure outcomes with methods that will uncover evidence that the intervention itself caused the participants to be able to attain these outcomes. These differences are illustrated below.

You can determine program outcomes by assessing how participant children and families look at the end of the program. Then you can compare these outcomes to the program's goals. For example, assume that a certain program's desired outcomes include caregivers spending at least 20 minutes each day with their child in uninterrupted and mutually enjoyable play or reading. By having caregiver participants report the amount of time they spend with their child each day during the final week of the intervention, an evaluator can determine whether this programmatic goal was met overall, or how many participants met the goal. Of course, this simple measure of outcome does not show whether the program itself created an increase in caregiver–child interaction nor does it "prove" that the program was the cause of the goal's being met. However, it does yield important information regarding the extent to which programmatic goals have been met and the degree to which these goals might be reasonable expectations.

Or suppose that your program hopes to facilitate the social–emotional and language development of toddlers living in risky environments, with the goal of helping them leave the program functioning at age-expected levels in these areas and ready for success in preschool. After assessing both

Table 2: An Evaluation Checklist

- ❑ Identify the core components of the program intervention, using both qualitative and quantitative information. (What is "it"?)
- ❑ Define the desired intermediate and final outcomes.
- ❑ Conduct needs assessments, community assessments, or both to place the program in the context of the population and community for which it is designed.
- ❑ Develop a logic model to express the knowledge produced so far and what you want to study, and revise the model based on feedback from program administration, service professionals, and the families being served.
- ❑ Conduct a process study to see if the program's implementation is consistent with the logic model.
- ❑ Adjust the logic model to fit what you have learned about the program's workings. (Stop here if your goal is to simply identify which parts of a program work well and which parts need improvement, or if a program is being implemented consistently with the way that it was planned.)
- ❑ Conduct outcome–impact analyses if you are interested in documenting the outcomes of the program (outcome study), or the effects that it produces (impact study).
- ❑ Use the knowledge gained to improve practice, contribute to knowledge about your field, inform social policy relevant to your program's goals, and/or to advocate for your program with external funders.

domains of development in children exiting the program, you might discover that the children's social relatedness is developmentally appropriate, but that their language skills are far below a desirable level. Because this is a "post-test" only, you don't know that your program caused the children to have adequate social relatedness; they might have achieved it even without the program. Nor can you say that your program failed to improve the children's language skills; they might have been even weaker without the program. But even though the design of this evaluation allows no causal inferences, you might still conclude that you want to pay more attention to language development in the program.

Program impacts are a more scientifically rigorous way of measuring program effects, because they seek to demonstrate a causal relationship between participation in the intervention and the desired outcomes. To show causation, outcomes for participants must be compared to some other benchmark that represents what the participant outcomes would have been had they not participated. Usually, this is accomplished by either comparing participant outcomes to (a) a group of children who were eligible to receive the intervention but were randomly selected to not receive it, (b) children who did not receive the intervention but are similar in important characteristics to those that did receive the intervention, or (c) the participants' own baseline performance on the desired outcomes. We discuss these three impact designs below.

Random assignment studies typically provide the best evidence that any beneficial program outcomes are due to participation in the program. Unfortunately, random assignment is often quite difficult for existing programs and services to implement, because some children are denied services and the mechanism for denying services is based on a random lottery. In some cases, such as instances where services are mandated or where the service is part of a legal entitlement (e.g., Part B and C special education services) denying services is either illegal or unethical. However, there may be other instances where children and families are placed on waiting lists due to a lack of availability of services. In such cases, if those who are served are randomly selected from a pool of those seeking services, a random assignment design might be possible. Assuming that the children and families in the treatment and no-treatment groups are similar in all meaningful respects except for their randomization to receive or not receive treatment, any differences in measured outcomes between the groups can be attributed to the intervention.

Comparison group designs are used frequently when randomization to a no-treatment group is not legal, ethical, or feasible, such as when there is an entitlement to services. Although the causal inferences are not as good as with random assignment, comparison group designs can lead to some very defensible demonstrations of the effectiveness of the program. What is most important is that the comparison group be as similar to the treatment group as possible on the important variables (Gilliam & Zigler, 2001). Obtaining a comparison group of children who were the same as the treatment group on their status on outcome measures before the treatment is ideal. In other cases, comparison children may be matched to the treatment group on other factors that may be a part of their eligibility for services, such as degree of poverty or some other risk factor. The biggest threat to the validity of this design is that children whose families are motivated to seek services (e.g., the program being evaluated) are compared to children whose families who were not motivated, and the best way to deal with this effectively is through random assignment.

Pretest comparison designs may be the most feasible strategy for small program evaluations on tight budgets. In this case, participants' outcome measures at the end of the program are simply compared to their functioning on the same measures before the program was begun. Although it is not possible to infer that the program is the only factor that could have caused a change in participants during the course of the intervention, this simple design has been used effectively in a variety of program evaluations, including the current national study of the quality and effects of Head Start (Zill et al., 1998). When using this design, take great care in selecting the outcome measures. If a desired outcome is a reduction in reported parental stress, then evidence of effects may be demonstrated by parent participants' report of lower levels of stress at the end of the intervention, relative to the beginning. If the desired outcome is an increase in children's language development, then the pretest (given at the beginning of participation) and post-test (given at the end) would need to address the effect of simple maturation on children's language development. In other words, there would be no way to know how much of the change in language development was due to the program versus the fact that the children matured over time. This could be addressed, however, through using age-referenced measures of development (e.g., Mullen Scales of Early Learning [Mullen, 1995], Developmental Observation Checklist System [Hrescko, Miguel, Sherbenou, & Burton, 1994]). Because age-referenced tests provide a measure of a child's developmental standing relative to same-age peers, these scores remove the effects of maturation and provide a clearer estimate of the program's impacts.

Cost–Benefit Study

Programs are sometimes asked to justify themselves by examining their operating costs relative to the benefits they achieve. There are three steps involved in conducting a cost–benefit analysis. First, document and total all of the costs of running a program (both direct costs and indirect, administrative costs). Second, divide the total cost of operating the program by the number of "units" served through the program (such as the number of children), producing the cost per unit. Third, calculate a cost–benefit ratio by dividing the cost per unit by the benefit per unit (as estimated through the outcome–impact study). This ratio may be calculated as a pure monetary ratio, such as a family support program that costs $5,000 per family but results in

$6,000 in welfare benefit savings, resulting in a 1.20 ratio, or 120% return on the initial investment. Or it may be calculated in terms of social outcomes, such as, "An average investment of $5,000 per child resulted in a 10% increase in the children's high school graduation rates 15 years later."

Building a Logic Model

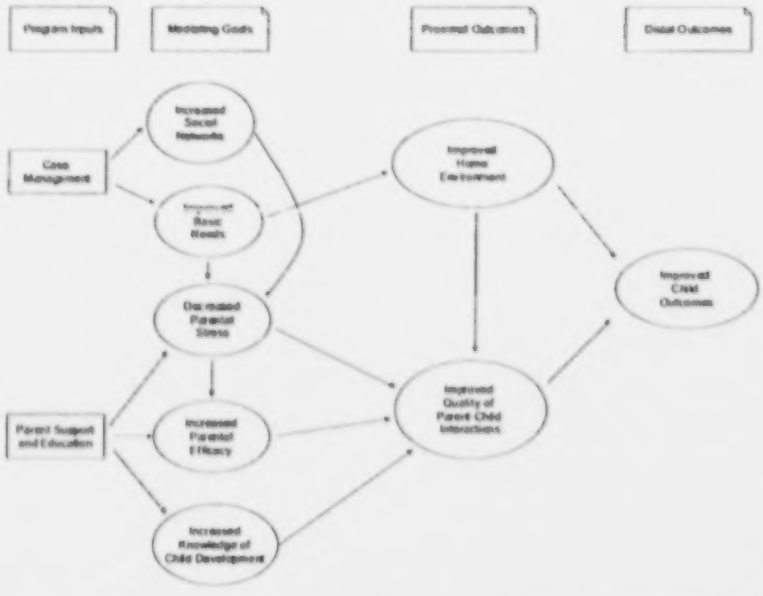
A logic model is a clear and logical explanation of how the various components of a program or service effect the changes in the participating children and families that move them toward the desired programmatic outcomes. As an essential part of any program evaluation, the logic model helps explain what the program is, what the major outcome goals are for participants, and how the program anticipates that those outcome goals will be reached. (Interested readers may read Unrau, 2001, who provided a useful description of how the logic model can be used to plan program evaluation, as well as how it is commonly misused.) It is only through building such a model that you can outline all of the important aspects of the program, and evaluate the likelihood of any anticipated outcomes. The logic model captures the program's theory of how families and children change and explains the aspects of the program that are most responsible for helping create those changes. The next few paragraphs describe ways in which you can begin to develop a logic model, how the preliminary model can be revised on the basis of feedback from program professionals and participants, and how measures can be attached in order to guide evaluation.

Getting Started

When building a logic model for a program, a variety of sources should contribute information and feedback. These sources may include program developers and administrators, staff in the field who are actually implementing the intervention, participant families, and funders. Input can be gathered both through formal focus groups with these program constituent groups and through soliciting feedback on the logic model as it is being developed. The important questions for stakeholders to answer include, "What are our primary outcome goals for children and families, and do we really think that we can achieve these goals consistently?," "What are the essential or important elements of our program that help us attain these goals, and do families actually receive these elements in the level of quality and quantity that we feel is necessary to achieve our stated outcomes?," "What kind of assumptions do we make regarding how the participants will change and what that change might look like?," and "What is the specific chain of logical changes that occurs in children and families that will ultimately lead to the desired outcomes?" Once you collect this information, you can construct a logic model to explain what elements of the program expected to result in what types of outcomes.

An example of a simple logic model is provided in Figure 1 below. In this logic model of a fictitious family support program, two main programmatic inputs, or service elements, are identified: case management for the family and a parent support and guidance–education service. The program implementers hypothesize that the case management element will increase participant families'

FIGURE 1: AN EXAMPLE OF A SIMPLE LOGIC MODEL FOR A FAMILY SUPPORT PROGRAM



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social networks by helping the caregivers to identify and use others in their extended families and community as support agents. They also aim significant resources toward helping the low-income participants in this program secure adequate housing, food, and basic utilities. The parent support and education component consists of weekly meetings with a parenting and child development consultant and weekly parental support groups, with the work focusing primarily on helping parents to find good ways to deal with their stress, learn and practice effective ways of interacting with their children, and adopt developmentally appropriate expectations for their children's behavior.

Each of these aspects of the work is reflected in the model's mediating goals. The program implementers further hypothesize that through working on these five key areas, families will demonstrate improvements in the stability of the home environment and in the quality of the interactions between the children and their caregivers, resulting in improved children's development. As the model is being developed, it is important that all of the important program stakeholders scrutinize each of the model's elements and arrows, paying particularly close attention to the degree to which they feel that the program inputs are actually focusing on improvements in the intermediate and final goals.

A wide range of data may be used in evaluation studies. Some data already exist within a program and only need to be organized (e.g., regulations and documentation of services and outcomes in participants' files). Other data may be collected for evaluation purposes.

Refining the Model

Once you have developed a logic model for your program, it is crucial that you collect preliminary data to assess whether the model actually fits what your program is doing. If you measure something that your program is not implementing fully, then your chances of obtaining good results are slim and you have wasted resources measuring something that you are not doing. Take this opportunity to refine what you are testing.

This initial assessment of your logic model is essentially a process study, to see if your program is doing what you think it is doing. Much of the data you would collect at this stage are qualitative, including interviews, observations, and case folder documents. These data will give you a "street level" sense of what is going on. The results of this initial assessment will help you refine your logic model and provide data for an overall process study.

Using the example in Figure 1, you may think that your program is decreasing parental stress and increasing parent efficacy as a result of parents' participation in support groups. You could have staff members who do not work directly with families interview parents about their experiences in the parent support groups, or have them conduct organized focus groups on this topic. But what if you find that the parents are not attending the groups regularly because child care is not always provided? Or if parents tell you that the other parents are not supportive, and that their case manager is their primary source of support? This is constructive information, which will allow you to refine the logic model you are testing and to document actual program practices.

Measurement

The next job in developing a logic model is to attach measurements to the circles and squares in your model. You will use these measures in the evaluation to determine whether the program was implemented appropriately, and whether participation in the program was associated with any of the desired outcomes. A wide range of data may be used in evaluation studies, including both quantitative (statistical) and qualitative (open-ended) information. Some data already exist within a program and only need to be organized: For example, there may be program documents (such as regulations, mission statements, or training materials) and documentation of services and outcomes recorded in participants' cases. Other data may be collected specifically for evaluation purposes.

Qualitative data on program operations and the experiences of participants and staff may be collected through three different methods: interviews, focus groups, and observations. Individual interviews may be conducted using a prepared list of questions (called an "interview guide"). Focus groups of staff or participants can be organized, in which a facilitator leads the group through a list of questions, promoting discussion between the group members. Data may also be collected through recording observations of actual program operations. For example, children's play groups or parent support groups can be observed by someone who does not take part in the group, but who takes notes on what happens. Typically, qualitative data are a key part of process studies, which attempt to document exactly how programs operate.

Quantitative data can often be attached directly to each of the bubbles in the logic model and collected at regular intervals. Given that one of the major mediating goals of the program is to reduce parental stress, you might administer to parents one of many valid measures of this construct, such as the Parenting Stress Index (Abidin, 1990) or the Parenting Stress and Competence Scale of the Developmental Observation Checklist System (Hrescko et al., 1994). In fact, many instruments are available that address a wide variety of areas to focus program efforts. You do not have to create new measures "from scratch." It is often better to use "standard" questions that have been used by other researchers in your field, especially studies that have been published in professional journals. By using established questions, you get the benefit of all of the testing that someone else has done to

make sure that the questions work properly, and you can compare your results with those from other studies that used the same questions.

The important thing to remember is that each bubble in a logic model can be measured in some way, and it is essential that you choose measures that are valid and appropriate to your program and the participants you serve. You should make attempts to use appropriate measures for as many of the goals and outcomes as possible and to focus as much energy as possible on measuring the intermediate goals and outcomes in the intervention, because this is where positive results are most likely and because the intermediate goals and outcomes provide the foundation for the final outcomes. It is easy for program evaluators to want to jump too quickly to measuring only the final outcomes, because these tend to be the most valued by program mandates and funders. However, without measuring success on the intermediate outcomes, all of your evaluative eggs are placed in the least likely basket and you can learn little about how the chain of anticipated outcomes for the logic model did or did not work.

Using Evaluation Findings

The findings from an evaluation study may be used in any number of ways, depending on your motivation for carrying out the study. You may want to investigate how your program is operating because you want to engage in a process of renewal and change. You may want to document the effects you are having, so that you can advocate for your program's continued (or increased) funding. You may be responding to external demands for program accountability. Or you may want to share what you have learned with your field, showing where you are having success with an approach (or where substantial challenges still exist). The particular goals of the evaluation should help drive which aspects of the evaluation are stressed. For example, if the primary goal is program quality improvement or demonstrating to a funder that the program has been implemented according to the model, then the evaluation might focus most heavily on the process evaluation. If the primary goal is to describe the impacts of the evaluation to advocate for continued funding, then a more formal evaluation of program impacts, contextualized in a way that is most appealing to the decision makers from whom you are addressing your advocacy efforts, might be most needed (Kirwan, 2001).

Getting Started and Getting Help

There are many individuals who you may want to enlist to help design and implement a program evaluation. For example, the New England Resource Center (2003) has recently developed a series of self-evaluation tools for Head Start programs, complete with a directory of potential consultants throughout the New England area. Other good sources of help include faculty members and graduate students at local colleges and universities. Many professors and graduate students in fields of study like psychology, sociology, social work, education, and epidemiology have program evaluation expertise and are looking for programs to evaluate for research projects. Graduate students are always in search of topics for master's theses and dissertations, and many would welcome an opportunity to consult and design an evaluation. Partnerships between programs and academics can be good exchanges: You could get your questions answered at little cost to your program, with the added strength of having outside, "objective" researchers do the work, while the researchers could get access to data they need to publish actively in their fields.

Program evaluation should be a constructive process, through which you learn exactly what your program is doing, what effects you are having, which parts excel, and which parts you may want to improve. You probably already have a great deal of data available on hand. Much of what your program does is documented piece by piece, in all of the paperwork you create and save. You might start by taking inventory of what information you already have, and then thinking about what additional information would be needed for an evaluation. You can start small or big, depending on your needs. You probably have more resources than you think on hand, once you look at them with an evaluative eye.

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14 BEST COPY AVAILABLE

Enhancing the Quality of Relationships in Infant–Toddler Child Care:

A Developmental Process

Mimi A. Graham, Anne E. Hogan, Barbara A. White, *and* Christine A. Chiricos

Florida State University Center for Prevention and Early Intervention Policy, Tallahassee, Florida,

Acknowledgment: Support from the A. L. Mailman Family Foundation made it possible to develop training based on the 10 Components of Quality. The Picower Quality Childcare Initiative is a collaboration among the Picower Foundation, the Children's Services Council of Palm Beach County, Florida, and the United Way. The Florida State University (FSU) Center for Prevention and Early Intervention, in partnership with Chapin Hall at University of Chicago, evaluated the 4-year project.

The single most important factor in early education and care is the relationship between the child and the caregiver (Carnegie Corporation of New York, 1994; Zeanah, Larrieu, Heller, & Valliere, 2000). Yet the quality of this relationship is rarely, if ever, adequately emphasized in any global measurement of child care quality. The Environmental Rating Scales (Harms, Cryer, & Clifford, 1998, 2003), probably the most widely used measure of quality care, weights all components equally. As a result, programs can score "inadequate" in "staff–child interaction" and "excellent" on "furnishings and program structure" and still achieve an overall rating of "good." Programs can achieve National Association for the Education of Young Children (NAEYC) accreditation, a widely respected indicator of quality, without implementing continuity of care or training staff in responsive caregiving and other critical social–emotional components of care. Although the Environmental Rating Scales and NAEYC accreditation criteria are extremely valuable, we believe that measures of child care quality must reflect *current* child–care research on the

at a glance

- A relationship-based definition of child–care quality can serve as a framework for continuous improvement.
- The 10 Components of Quality—including primary caregiver and continuity of care, and active and responsive caregiving to support children's development—give prominence to relationships and social–emotional development.
- Front-line caregivers, center directors, and funders need to have a common vision of child–care quality.
- Most child–care programs need several years to integrate all components of quality, including relationship-based care.

Photo Courtesy of Florida State University Center for Prevention & Early Intervention Policy

centrality of the caregiver–child relationship. Moreover, our experience suggests that a relationship-based definition of child–care quality can serve as a framework for continuous improvement.

The 10 Components of Quality Child Care

With support from multiple funders, we developed the 10 Components of Quality Child Care (Florida State University Center for Prevention & Early Intervention Policy, 2003). Based on earlier work at ZERO TO THREE (Lally, Griffin, Fenichel, Segal, Szanton, & Weissbourd, 1995), the new components give appropriate prominence to relationship components of quality child care. Two of the 10 components directly address the quality of relationship components (primary caregiver and continuity of care, and active and responsive caregiving). The remaining eight components support social–emotional development. Information on the research basis and accompanying training on the 10 Components of Quality is available at www.cpeip.fsu.edu.

1. Licensed Programs Following Appropriate Health and Safety Practices

Licensing ensures that a child–care setting meets basic health and safety requirements. In addition, quality child care settings for young children have separate areas for food preparation and diapering/toileting; detailed procedures for emergencies; policies for addressing illnesses; nutritious meals and snacks; collaboration with community health and safety resources; and frequent hand washing by caregivers and children to minimize the transfer of infections. To reduce the risk of SIDS, all healthy infants should be placed on their backs to sleep.

2. Staff Well Trained in Early Childhood Development

The strongest indicators for long-term success tied to early education and care are related to the caregivers' education and level of participation in ongoing training in the field of early childhood development and care. Staff competence is the most important contributing factor to a social environment that facilitates early learning. Caregivers should apply their knowledge of early childhood development and use curricula and materials to plan appropriate activities and provide responsive caregiving. Caregivers should also use routines to promote learning and look for opportunities to have meaningful conversations and interactions with children.

3. Age–Appropriate Environments

Learning is an interactive process that involves continuous opportunities for exploration and interactions. Infants and toddlers should have age-appropriate equipment and spaces, both inside and outside, that are separate from those used by older children. Room arrangements should allow for both quiet and active play, dramatic and messy play, large group activities, and individual care. Multiple sets of the same toys prevent conflicts. Toys and books should be available for access at the child's level to promote independent choice and use. High-quality programs arrange classrooms to facilitate young children's learning, rather than to accommodate the preferences of adult caregivers.

4. Small Groups with Optimal Ratios

Group size and ratios determine the amount of time and attention that each caregiver can devote to each child. Small groups create a sense of intimacy and safety. A rich dialogue between caregivers and infants is possible in small groups because there are fewer people, less noise, and less activity to interfere with a child's ability to learn. Small groups and more staff enable caregivers to build strong relationships with each child and to adapt activities to meet the changing interests and needs of the group.

The recommended group size for infants is six to eight. The best adult-to-child ratio is one adult for every three or four infants.

5. Primary Caregiver and Continuity of Care

Positive relationships between caregivers and children are crucial to quality child care. It is through close relationships with caring adults (including caregivers) that children flourish, discover their world, and learn who they are. Each child enrolled in group care should be assigned a primary caregiver. A primary caregiver has the principal responsibility for that child and helps build a positive, constant, intimate relationship with the child. The primary caregiver also offers family members a consistent contact who knows the child well.

Having one primary caregiver for more than a year (optimally, from entry into child care until the child is 3 years of age or older) is important to a child's emotional development. Each change from one caregiver to another takes a toll on the child. When young children are repeatedly changed from one caregiver to another, the process of grieving the loss of the previous caregiver and learning the new caregiver's ways may slow their overall development and leave them reluctant to form new relationships.

6. Active and Responsive Caregiving to Support Children's Development

The active and responsive caregiver takes cues from each child to know when to expand on the child's initiative, when to guide, when to teach, and when to intervene. Responsive caregivers are alert to signs of stress in each child's behavior and respond with appropriate stress-reducing activities and techniques. The responsive caregiver continuously facilitates the development of self-esteem by respecting and accepting children, regardless of their behavior.

7. Emerging Language and Literacy

The path to literacy begins with interactions between caregivers and young children. Caregivers expand on the vocalizations of infants and toddlers, and add words and ideas to what very young children express, feel, or say. They promote the development of language through the use of simple words and maintain a balance between listening and talking with the child. Songs, nursery rhymes, and finger plays promote the development of language and literacy. Staff create a learning environment that includes books and other print material throughout the child-care setting. Opportunities for shared reading are a part of each day. Children are encouraged to enjoy books independently.

8. Curriculum, Observation, and Individualized Programming

Learning involves activities, materials, and opportunities for exploration and interaction. Staff in quality programs use curricular resources to plan and prepare an environment in which children can choose from a variety of activities. Caregivers also understand the temperaments, moods, and preferences of each child. They adapt sleeping, eating, and play routines to meet individual needs. Children's special abilities, as well as disabilities, are continuously discovered as caregivers routinely observe and assess each child. Based on curriculum and observations, caregivers develop an overall plan for each day, individualizing activities, materials and schedules according to the developmental stage of each child.

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9. Family Involvement and Cultural Continuity

High-quality programs incorporate practices reflecting the values and beliefs of the families and the cultures of their communities. Using the child's home language, following cultural norms related to daily routines, and celebrating diverse cultures are examples of such practices. Caregivers should communicate each day with families, welcome parents into their child's classroom, and organize special events that include the child's family members.

10. Comprehensive Support Services

High-quality child care serves as a protective environment for the child and a source of support for the child's family. Because child care cannot meet all the varied needs of young children and their families, linkages with community agencies are essential to provide a medical home, mental health and social services, and therapeutic interventions. Ongoing communication can ensure continuity of care across multiple disciplines and promote holistic support services and treatment.

Developmental Progression of Change in Early Care and Education Settings

Communities can use the 10 Components of Quality Child Care, in conjunction with global quality scales, to strengthen relationship-based care in their early care and education programs. Most programs need several years to integrate all the components of quality — facilities, health and safety, group

size, well-trained staff, and relationship-based care. Changing a child–care program or a child–care system involves:

- articulating a common vision of quality,
- translating that vision into a detailed action plan,
- securing the skills and resources needed, and
- implementing the plan to achieve the desired change.

Articulating a Common Vision of Quality

Front-line caregivers, center directors, and funders need to have a common vision of child care quality. The 10 Components of Quality are grounded in both research and practicality. When trainers and consultants present visual examples of the 10 components, all staff can picture what quality looks like in the classroom. Site visits to model programs help directors and caregivers see how continuity of care actually works or how caregivers infuse literacy into daily routines. A common vision of quality helps build a common will for change.

Like developmental progression in children, qualitative changes in early care and education programs typically proceed in a predictable developmental sequence.

Action Plan

A common vision of quality must be translated into a detailed set of actions that will achieve the vision. The Environmental Rating Scales (Harms et al., 1998, 2003), which rate quality of classroom furnishings, personal care routines, language, learning activities, program structure, and parent–staff needs, provide a baseline measure of the child care environment. In addition to this quantitative perspective, interviews with program administrators and key staff, guided by the 10 Components of Quality, provide a qualitative view of staff perspectives on the care at their center. Both types of information form the basis of a "quality improvement plan" with goals, actions, timelines, and assignments of responsibility. The success of the plan will depend upon the commitment and skills of the center director, the motivation of the direct caregivers, and the availability of training and technical assistance.

Resources

Abundant resources are available in the field to support the social–emotional development of young children. However, few programs are familiar with classic resources such as the Program for Infant-Toddler Caregivers' (West Ed., 1995) videotapes and trainings; the video, *10 Things Every Child Needs* (WTTW Chicago, 1997); or the publications, Web site, and training resources of ZERO TO THREE. To improve quality, child–care programs need to devote resources to the components that directly affect quality. In order for regular hand washing to occur, for example, sinks must be easily accessible. Age-appropriate environments require child-size equipment. Small groups require room partitions or additional space. Curricular activities require age-appropriate learning materials. Comprehensive support services require specialized staff. Many child–care administrators cite "lack of resources" as the explanation for poor facilities, large group size, developmentally inappropriate playgrounds, lack of child-size sinks and toilets and noncompliance with Americans with Disabilities Act requirements. But many other administrators are extraordinarily resourceful about getting civic groups, parents, or grants to help build playgrounds, or sponsor events, or volunteer services. Whether purchased or donated, resources are essential for creating and maintaining quality.

Building Skills

Achieving child–care quality requires the skills of center directors, caregivers, and support staff. The director's leadership skills are needed to identify barriers to quality, assess staff's need for skills, create a plan for achieving skills, and marshal necessary resources. Teachers' skills, as many research studies have found, represent a critical component of quality child care. Multidisciplinary support staff must have content knowledge in their field and skills in addressing the needs of young children and families.

Caregivers' Individual Professional Development Plans can be linked to the 10 Components of Quality. Individual and group training, hands-on modeling, and mentoring help staff learn and practice skills along a continuum of complexity. Concrete components of quality are easy for most staff to master — for example, "putting art at child level," arranging the classroom, and making sure there is a designated block area. Some skills — even routine ones such as hand washing — tend to require hands-on modeling and continuous reinforcement. Higher-level skills, such as responsive caregiving, seem to require training, extensive mentoring, and ongoing encouragement within the context of relationships. Intensive, structured training, combined with on-site mentoring for caregivers and consultation for directors, can quicken the pace of skill building. "One-shot" trainings are rarely effective in building skills, but mentors can provide hands-on help to caregivers in applying and practicing concepts from training.

The Developmental Process of Change

Our experience in program development suggests the existence of a phenomenon that we call the "developmental process of change." Like developmental progression in children, qualitative changes in early care and education programs typically proceed in a predictable developmental sequence. Like children's development, improvement in child–care quality proceeds from the concrete to the more abstract, from the general to the specific. Changes in facilities and materials are more easily achieved than changes in behavior. In an early care and education setting, change seems to trickle down from the overall center environment, to the classroom, to the caregivers, until it touches the children.

- ***Basic facilities layout, equipment, and materials.*** Improving a child–care facility might include painting, replacing carpet or tile, and landscape or playground improvements. Kelling and Coles' (1996) "broken window" theory suggests that if one window on a block is broken and remains so, residents will become indifferent to more broken windows. Changes that staff and parents can see may inspire more qualitative changes. And a facility that is clean, freshly painted, and well taken care of increases pride in the workplace.

- ***Health and safety, hand washing.*** Caregivers easily understand the importance of health and safety issues. Training that is followed up by regular accountability checks can institutionalize changes in procedures like diaper changing, frequent hand washing (by both caregivers and children), cleaning toys, and dealing with ill children.

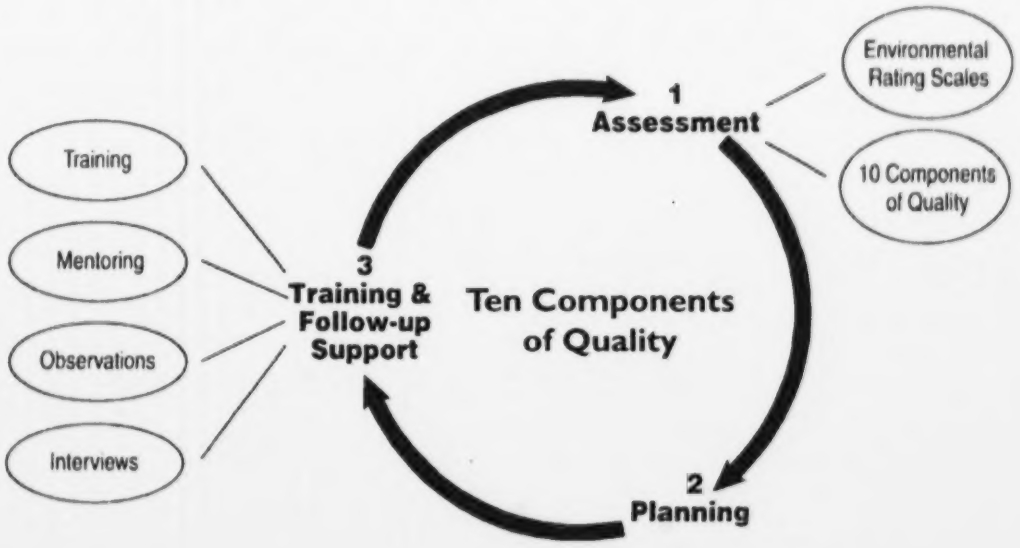
- ***Group size and ratio.*** Caregivers welcome decreases in group size or ratio or both. Although these are often economically challenging for programs, decreases in group size or ratio typically result in immediate positive changes in both staff and child behaviors. Caregivers are less stressed because they are responsible for fewer children. Young children in smaller groups have fewer other children with whom they are competing for their caregiver's attention and as a result tend to exhibit higher levels of play, appear calmer, and display fewer behavior problems. When an early care and education setting can make progress in facility improvement, more rigorous attention to health and safety, and more nearly optimal group size and ratio, overall quality improves.

- ***Well-trained staff.*** When all of the above changes are implemented and the subsequent positive outcomes for both staff and children are evident, caregivers often acknowledge that the program is committed to quality. Staff are typically more enthusiastic about training opportunities and become proud of their accomplishments. As a result, caregivers learn more about the needs of infants and toddlers, and staff competence increases in areas like planning developmentally appropriate activities.

- ***Relationship-based care.*** Relationship-based care is typically much more challenging to implement than other aspects of quality. This change in attunement to the individual needs of the children necessitates change in behaviors. For example, "contraptions" are removed and caregivers are encouraged to get down on the floor interacting with children. Staff are more responsive to children's distress, quickly and appropriately responding to their needs and temperaments.

- ***Quality.*** A child care setting's process of change can be called successful when all 10 components of quality are integrated into the setting's practice — facilities, health and safety, group size, well-trained staff, and relationship-based care. This process of change typically takes years to achieve, however. Small changes should be celebrated and reinforced.

FIGURE 1: MODEL FOR CONTINUOUS IMPROVEMENT OF QUALITY CARE



Measuring Quality Improvement in Child Care

If we accept the 10 Components of Quality as a description of child–care quality and also recognize that child– care settings move toward quality through a developmental progression, how should achievement of and adherence to quality be documented and monitored? We propose a 3-step model for continuous quality improvement, illustrated in Figure 1.

Step 1: Continuous improvement begins with the collection of baseline information about the early care and education environment. The Environmental Rating Scales provide a valuable quantitative measure of classroom furnishings, personal care routines, language, learning activities, interaction, program structure, and parent–staff needs. Using the 10 Components of Quality as a framework for self-evaluation, evaluators ask program administrators and caregiving staff how, in their view, their center addresses each component. Step 1 identifies clearly the center's areas of strengths and needs for improvement.

Staff are typically more enthusiastic about training opportunities and become proud of their accomplishments. As a result, caregivers learn more about the needs of infants and toddlers, and staff competence increases in areas like planning developmentally appropriate activities.

Step 2: The evaluators draft a report and discuss it with the director and mentor, coach, or technical assistance provider who will be working with center staff over time. With concurrence of the director, the mentor drafts the improvement plan for the center. The mentor and director also develop individual quality improvement plans for each classroom and their staff. The mentor meets weekly with staff to prioritize and pace improvements to ensure staff buy-in and reduce resistance to change. This enables the development of a "quality improvement plan" with goals, actions, timelines, and person(s) responsible.

Step 3: Implementation of the quality improvement plan depends on a continuous cycle of assessment, planning, training, and support followed by reassessment, planning, training, and support. Activities might include training workshops, mentoring and professional support for directors and caregiving staff, observation and feedback, and attitude and perception interviews. Trainers remain focused on the common vision of quality and the use of a continuous quality improvement model for change that will remain in place within programs over time. Trainers help staff use reflective practice so that they are likely to remain focused on improving quality long after the "project" is over.

Using the 10 Components of Quality to Build Quality Child Care: A Case Study

The Picower Quality Childcare Initiative (a collaboration among the Picower Foundation, the Children's Services Council of Palm Beach County, and the United Way) provides an instructive case study of the use of a relationship-based definition of child care quality, as well as a quality improvement framework for evaluation. The goal of the Initiative was to improve the quality of six child care centers in two communities in Palm Beach County, Florida, with plans for countywide expansion. The Florida State University (FSU) Center for Prevention and Early Intervention Policy was engaged originally to evaluate the Initiative. FSU expanded its role to help the Initiative use its resources to facilitate implementation of the 10 Components of Quality.

Establishing a common vision of quality was the Initiative's first task. Although everyone from the funder to the frontline caregivers aspired to "quality," stakeholders lacked a common definition. When Board and staff of the Initiative were presented with the 10 Components of Quality, the Components then became a framework for organizing change. The Initiative's resources made it possible for participating centers to:

- upgrade their facilities;
- establish comprehensive services teams to identify and refer children needing health, developmental, behavioral, and social supports; and
- undertake staff development and mentoring by masters-level early childhood experts (one for each participating center).

Improvements in these areas provided a foundation for achieving additional Components of Quality.

In the Initiative's first year, facility upgrades (critical for NAEYC accreditation) provided participating centers with computers, landscaping, playground equipment, teacher lounges, painting, carpeting and tile, and sinks. The second year of the Initiative focused on training. In one of the communities, almost 60% of the staff completed the 15-week High/Scope program; in the other community almost 80% completed the High/Scope or West Ed. training. Any staff member who completed training received a $500 bonus.

Beginning in the second year, a full-time mentor worked with each center. The mentor attended training with staff and then helped caregivers apply the concepts in the classroom, linked to the 10 Components of Quality and each center's quality improvement plan. Year Three is focusing on enhancing relationship-based care.

Evaluation and Continuous Improvement in the Picower Initiative

We believe that the 3-step process for continuous quality improvement — identifying the problem, mapping out an improvement plan, and hands-on mentoring and modeling—facilitated and accelerated improvements in child care centers in the Picower Initiative. The success of individual plans depended upon the commitment and skills of the center director, the motivation of the direct caregivers, and the availability of training and technical assistance.

Early in the Initiative, we assessed each classroom in the six participating centers, using the Environmental Rating Scales. This process gave us standard baseline measures of quality, which provided the rationale for planned improvements. These, in turn, could be measured in re-assessments. Mentors worked with directors and teachers to develop improvement plans. Mentoring and modeling helped to achieve the improvements. Evidence of improvement was noted in the "post" ITERS/ECERS ratings.

We used interviews with front-line caregivers to find out how they perceived changes in quality at their centers and how additional supports provided by the Initiative were affecting them. We asked participants to rate how the Initiative had enhanced each of the 10 Components of Quality at their center. They were asked to identify which components had changed most (health and safety practices, and staff training) and which had changed least. We found that interviewing front-line caregivers individually encouraged them to reflect on their experience with the Components, and, moreover, validated directors' statements that caregivers' views about change were important. The ongoing qualitative information provided by the interviews has not only helped clarify what components are perceived as needing or demonstrating change, but also has helped show how supports such as mentors and service teams can bring about such changes

We attribute improvements in the quality of care at participating centers to a combination of the intensive mentoring relationship and extensive training. Although program developers may have clear ideas about how various activities and supports may specifically enhance quality, the process of relationship-building and communication about roles does not occur automatically. Assigning mentors to a specific center helped mentors "earn the right to influence" and seemed to accelerate positive change. Because mentors attended intensive High/Scope and West Ed. trainings with the caregivers, they were better able to help caregivers apply concepts from the trainings to their daily work. Because mentoring is, itself, a reflective relationship, it can be used as a vehicle for reflection on how to improve all relationships in child care contexts.

In addition to mentors, Comprehensive Services Teams were available to the participating centers to identify and refer children needing health, developmental, behavioral, and social supports. Prior to the Initiative, few caregivers knew about the Individuals with Disabilities Education Act (IDEA) or where to refer children with special needs. During the Initiative, the early identification of children with special needs increased significantly, and referrals were made to address a variety of concerns.

The Picower Initiative has provided significant resources to help early care and education programs implement their vision of quality. Thousands of dollars were spent in equipping classrooms and playgrounds to meet NAEYC accreditation standards. Significant resources were spent in upgrading facilities such as painting, replacing carpet, planting flowers, and landscaping. Substantial human resources were provided including the mentors (now called early learning coaches) and Comprehensive Services Teams. The Initiative also supported High/Scope and West Ed. training for caregivers and mentors.

In Conclusion

The Picower Quality Childcare Initiative illustrates the use of a relationship-based framework for ongoing evaluation to build program quality over several years. Staff, mentors, and evaluators have brought about improvements by translating a common vision of quality into a set of specific actions and using available skills and resources to implement plans for improvement. Evaluation activities can play a crucial role in program development. Relationship-based practices can play a prominent role in early care and education.

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PHOTO: JANET BROWN MCCRACKEN

PROJECT CONNECT:
Seeing the Forest and the Trees

GAMBI WHITE-TENNANT
Infant/Toddler Specialist, New York University/The Steinhardt School of Education
Head Start Quality Improvement Center (Q.I.C.)

Continuous improvement is an important part of the landscape in the Head Start world. A continuous improvement process allows programs to observe over time the effectiveness of program services as well as the appropriateness of service delivery. Many programs, however, implement some aspect of a continuous improvement system but fail to establish a way for data to significantly affect program operation. Project Connect grew out of my ZERO TO THREE Fellowship experience as a way to help Early Head Start (EHS) programs implement a *comprehensive* continuous improvement process. I chose to follow the continuous improvement process presented in the *Administration for Children and Families Information Memorandum* (Administration for Children and Families, Head Start Bureau, 2000). Although this model was presented primarily for the Head Start preschool population, Project Connect adapted it for infant–toddler programs.

Project Connect had three goals:

1. To improve consistency and credibility of screenings and ongoing developmental assessments for infants, toddlers, 2-year-olds, and 3-year-olds;
2. To design an approach to analyze data on the progress and accomplishments of infants, toddlers, 2-year-olds, and 3-year-olds; and
3. To incorporate screening and assessment data on infants, toddlers, 2-year-olds, and 3-year-olds into the program self-assessment system.

Three EHS programs participated in the pilot phase of the project. This article describes how Project Connect unfolded in one program, which provides comprehensive child development services to infant and toddlers and their families through a home-based program in a rural area. The program was invited to participate in the pilot phase of Project Connect, and eagerly accepted.

Initial Discoveries

As Project Connect Leader, I chose to work with only one home visitor in this program, her supervisor (the EHS education manager), and the EHS director. Keeping the implementation team small would allow us to continuously evaluate the process and quickly make changes, if needed. The group met monthly at the program site, with me as facilitator.

In the initial meetings we planned to:

- Review the program's screening and assessment approach and practices;
- Discuss how the program could use screening and assessment results to individualize practices;
- Identify the role and responsibility of parents in the entire screening, assessment, and curriculum planning process;
- Determine the extent to which the program's current curriculum approach adequately supported the development of individual infants and toddlers;
- Discuss strategies and techniques for documenting projected strategies and techniques to be used with each child, based on the screening and assessment data;
- Evaluate the data collected on the child and family to determine further training and technical assistance that the home visitor and/or manager might need to inform the curriculum approach, and to create or revise program plans concerning early care and education services.

Before I met with the program staff, I had planned to review the screening and assessment tools they were using to determine how best to collect data from these instruments. However, during our first meetings I learned that staff were not using an assessment tool. Home visitors were not conducting screenings systematically or recording observations of children consistently. They were not using information from screenings to inform curriculum planning (Twombly, 2001); indeed, home visitors were not using any curriculum consistently.

These discoveries presented a challenge that I had not considered. How could I help the program achieve all the goals of Project Connect in the single year we had to work together?

Changing Focus

In response to the program's urgent needs and eagerness to get involved in the process of continuous improvement, we changed focus. Instead of focusing on collecting screening and assessment data, I helped the program take a systematic approach to curriculum planning. Instead of meeting to discuss data collection and analysis, we researched various curricula to determine their appropriateness for the program's service delivery option (home-based) as well as for the children, parents, and staff. We discussed the usefulness of the program's current record-keeping format and determined what information should be added and what should be removed.

The Project Connect team identified a curriculum that would be appropriate for their home visiting model. They found a screening tool to complement the tool they had been using. They began to adapt their data collection forms to better meet their program goals, asking themselves: What information do we really need? Why do we need it? What are we going to do with it? How would this information help us to improve what we are doing? Next the team designed a system to incorporate data from the screening and assessment tools, observations, medical and nutritional information, and parents' reports of their child's interests and progress (Administration for Children and Families, Head Start Bureau, 2001). The home visitor collects all this information in order to create or revise a developmental plan for each child. The developmental plan is developed in partnership with the parents.

Implementing a New Process

One year later, the pilot home visitor had successfully implemented a systematic process for screening, assessment, and curriculum planning with her focus families. This new process includes 6 steps:

1. Using two complementary screening tools.
   One tool screens the areas of communication, gross and fine motor functioning, problem-solving, and personal–social development. The other screens social–emotional areas of development.
2. Obtaining updated medical and nutritional information.
3. Collecting and reviewing observations recorded during this period.
4. Developing and revising individual development plans with parent.
   With input from the team and the parents involved in the pilot project, the home visitor created a bright, colorful format for the plan, including a photograph of the child that is taken during the period in which the plan is developed.
5. Implementing the developmental plan.
6. Assessing the child's developmental progress.

at a glance

- A pilot Early Head Start project focused on using screening and assessment data to individualize curriculum planning and implementation.
- A change in project focus, reflecting program needs and an emphasis on continuous improvement, led to a comprehensive redesign of data collection.
- Preliminary results from the pilot project led staff to demand immediate program-wide implementation of the new process for screening, assessment, and curriculum planning.

The home visitor and her supervisor believe that the individual development plans created through Project Connect have helped parents to become more involved in the program. Parents have reported taking copies of their children's plans to their pediatricians, babysitters, grandmothers, and early intervention programs. They have begun to take a significantly more active role in home visits by initiating conversations on their child's development gains, suggesting activities based on these developmental accomplishments, initiating reports and discussion of their child's developmental progress, and sharing their own strategies for supporting and stimulating the child's development through everyday interactions and activities.

The initial Project Connect plan called for the pilot home visitor to implement the system of screening, assessment, and curriculum planning with the pilot families. Then the program would move on to program-wide data collection, analysis, and summarization of data, and integration of findings into the program self-assessment process (goals 2 and 3 of the project, above). However, when the Project Connect home visitor shared her success stories with her colleagues in the program, they wanted to implement the new process immediately. They felt that it was no longer fair to families in the program to delay implementation of the screening, assessment, and curriculum planning process because we had "proved" that the new approach was valuable.

The Project Connect team (the home visitor, the EHS education manager, the EHS director, and myself) discussed the argument that the home visitors put forth. The team decided to implement the screening, assessment, and curriculum process across the home visiting staff before continuing on with the other steps. I conceded to their decision. Clearly, the program had made the process their own. I believed that they would naturally go on to data analysis and program self-assessment after they had implemented the screening, assessment, curriculum planning system we had created together.

Lessons to Be Learned

Programs seeking to evaluate and improve their services can learn from the experience of Project Connect:

- ***Spend time talking and listening to each other about your program.*** Are you doing what you say you are doing? How do you know? What services are you delivering? Are they touching participating families in a meaningful way? What are your program's strengths? What elements of your program are you not implementing well — or at all?
- ***Discuss what information you are already getting*** that will help you evaluate your program. What additional information will you need to help you determine your program's effectiveness?
- ***Discuss how you will use the information*** you have gained to improve your program. Be creative. Think of responsive, respectful ways to improve your services for participants in your program. (Strategies to improve services for families in a center-based program may not be the best strategies for families in a home-based program.)
- ***Be flexible*** throughout the evaluation process. Be willing to make changes based on evaluation findings.

A year–long experience with Project Connect suggests that getting lost in the forest isn't such a bad thing — if we start looking at each tree individually as we try to find our path. Getting a good look at both the forest and the trees helps us understand all parts of the landscape and become wiser guides and traveling companions for very young children and their families on their life journeys.

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Incorporating Principles of Family-Centered Practice in Early Intervention Program Evaluation

Laurie A. Dinnebeil
and
Lynette M. Hale
University of Toledo, College of Education

How do early intervention (EI) practitioners and policymakers know if their efforts to support families have been successful? Are families receiving services that they consider to be valuable and that result in child and family outcomes that they view as meaningful? What is the role of families in answering this question? Given the field's strong commitment to family-centered practices in EI, these questions lie at the heart of program evaluation issues related to EI practices. In this article, we present an overview of current issues related to evaluating family outcomes in EI, with a focus on family satisfaction. We also offer guidelines that programs might feel are helpful when conducting evaluations that are consistent with family-centered practices.

Professionals involved in the delivery of EI services have long accepted the notion that the purpose of EI is to support not only the development of infants and toddlers with special needs, but also to support their families (Bailey, 2001; McWilliam et al., 1995). EI embraces the value of family-centered practices, a value that rests on the assumption that if families are supported, they will be in a better position to support their children's needs and enhance child outcomes. Family-centered practices include providing EI services that (a) are individualized, (b) involve families in decision-making about the nature and extent of services, and (c) enable families to feel competent in meeting their child's needs (Trivette & Dunst, 2000). In keeping with this overarching goal, efforts to determine the efficacy of EI programs have expanded to consider benefits for families as well as for children. However, while there is general agreement regarding desirable benefits for children, the field continues to wrestle with how to effectively evaluate how EI benefits families, and how outcomes for families should be measured (Bailey, 2001; Bailey et al., 1998; Dunst & Bruder, 2002; Simeonsson et al., 1996; Wesley, Buysse, & Tyndall, 1997).

at a glance

- To involve families in program evaluation, identify clearly defined outcomes that reflect families' priorities.
- Conduct program evaluations that help administrators understand the relationships between specific program practices and program outcomes.
- Find credible and reliable ways to evaluate what families value.
- Include multiple ways for families to become involved in the program evaluation process.
- View families as allies in the evaluation process.

More importantly, Bailey (2001; Bailey et al., 1998) reminds us that although a number of instruments exist to measure aspects of family involvement, the field still has not even reached agreement as to what constitutes desirable family outcomes.

Simeonsson and his colleagues (1996) provide evidence of the importance of having clearly delineated expectations or outcomes from the outset. They note that the families' values and expectations affect their satisfaction with a program. Therefore, if service providers and families are in tune from the beginning about what are reasonable outcomes, the likelihood of families being satisfied increases. Dunst and Bruder (2002) echo these concerns and point out that the confusion over expected outcomes for families has hampered efforts to measure the effectiveness of intervention practices aimed at supporting families. For example, in their research examining outcomes of service coordination, a key activity of Individuals with Disabilities in Education Act (IDEA) Part C services, Dunst and Bruder note that failure to delineate expected outcomes has lead to an "overpromise" regarding the outcomes and benefits of service coordination (p. 361).

Families value relationships with skilled and competent professionals. Program evaluation efforts should focus not only on the competence of professionals but also on the relationships they have with families.

What *Do* Families Value and Expect From Their EI Program?

How can we know if families are satisfied with the EI services they receive? A lack of consensus about desirable family outcomes should not stop programs from trying to determine the impact of their efforts. Researchers who examined issues related to state-level evaluation of EI programs concluded that family outcomes could be categorized under (a) service-related outcomes, (b) satisfaction outcomes, and (c) quality of life outcomes (Roberts, Innocenti, & Goetze, 1999). Bailey (2001) would add family knowledge of child development and how families use this knowledge to meet their child's needs. Dunst and Bruder (2002) asked practitioners and families to identify outcomes related to three specific Part C activities: service coordination, EI, and natural environments. Only two categories of outcomes, family satisfaction and family quality of life, spanned all three Part C activities. Efforts to delineate desirable outcomes and practices should be guided by the knowledge that families consider these two outcome categories worthwhile. Bailey et al. (1998) suggest that indicators of family satisfaction with EI services include the degree to which the family sees EI as making a difference in their *child's life* and *family's life* (emphasis added), and to which the family views both the service system and the professionals operating within it in a positive manner.

EI Program Practices That Families Value

The current emphasis on evidence-based practices means that programs must examine how their practices impact intended outcomes. If the field is to move ahead, efforts must intensify to identify and effectively measure desirable family outcomes. According to Roberts et al. (1999), evaluation efforts must reflect not only the impact of EI services on families, but also the efficiency with which services are delivered. As part of the process of providing high-quality services that result in desirable outcomes, programs must identify those features or components of EI programs (e.g., service delivery options, program policies, actions of personnel) that appear to be related to specific desirable outcomes.

An ongoing theme that has emerged from many studies (Dinnebeil, Hale, & Rule, 1999; McWilliam et al., 1995; Wesley et al., 1997) in determining satisfaction with EI services is the quality of the relationship that exists between families and EI professionals. In the study conducted by Dinnebeil, Hale, and Rule (1999), even when parents were asked to only identify program practices that had helped or hindered collaboration with their service coordinator, many parents commented on the behaviors of the individual professionals within their responses about their program. An earlier study conducted by Dinnebeil et al. (1994) that focused on characteristics of service coordinators revealed that families were most satisfied with professionals who were competent and whose actions reflected a family-centered approach.

A study conducted by Dinnebeil and Hale (1999) related to service coordination revealed some of the specific characteristics and actions of service coordinators that parents valued; those they considered most valuable included knowledge of relevant community resources, the ability to teach parents how to meet their children's needs, and knowledge of child development. Those considered least important included being efficient and well-organized, and being a parent. Additionally, parents rated activities such as completing paperwork and monitoring the family's Individualized Family Service Plan (IFSP) as indicative of their service coordinator's effectiveness. Actions perceived as less effective were increasing parents' awareness of community advocacy programs that could help them and working with medical and health providers to coordinate services.

Families value relationships with skilled and competent professionals. Not only should program evaluation efforts focus on the competence of professionals, but on the relationships they have with families as well. Documenting the specific program features associated with intended outcomes will enable researchers and practitioners to see how variations in program features effect variation in outcomes (Dunst & Bruder, 2002).

This knowledge will guide programs in providing services and engaging in practices associated with positive outcomes. Families and practitioners will have a more focused and realistic view of where they are headed.

How Can We Best Measure Family Satisfaction With EI Services?

Although many efforts at program evaluation have focused on measuring family satisfaction, Bailey et al. (1998) and Wesley et al. (1997) argue that family satisfaction as a global construct is not useful for determining efficacy. Although it would appear that asking families (i.e., the consumers) if they are satisfied is a way to involve them in evaluation efforts, assessing overall satisfaction is not enough if evaluation efforts are to also be reflective of a family-centered philosophy (Wesley et al., 1997). Furthermore, Bailey et al. (1998) and Wesley et al. (1997) caution against using parent satisfaction as a single measure of efficacy

Figure 1: Guidelines for Involving Families in the Program Evaluation Process

Guidelines	Points to Consider
Identify clearly delineated outcomes that reflect families' priorities.	Know what families want from the program. Do they expect certain services? Are their expectations related to the quality of life for their families? Do they want programs to focus on their children's development? Do they want to know how they can help their children develop? Remember that most parents have multiple expectations for the EI program and program evaluation must be able to attend to all of these priorities.
Conduct program evaluations that help administrators understand the relationships between specific program practices and program outcomes.	Understand what it is about the program that supports or gets in the way of positive outcomes for families. For example, having private spaces where parents can meet with EI providers or others can help to reinforce the degree to which parents feel supported and valued.
Find credible and reliable ways to evaluate what families value.	Remember that global measures of satisfaction are often unreliable because most families haven't been involved in EI programs prior to their current involvement. Many parents are grateful for any kind of service that they receive and have difficulty accurately determining quality services. While parent satisfaction is an important construct to consider in program satisfaction, the way that one measures satisfaction heavily influences the quality of information received.
Include multiple ways for families to become involved in the program evaluation process.	Families are diverse and have diverse needs and abilities. Program evaluation efforts should have multiple components and should encourage family input in multiple ways. For example, although some parents might feel comfortable participating in a focus group, others would not. A telephone interview might effectively involve a family member with limited literacy skills, while other parents would prefer to complete a written questionnaire.
Partner with parents as a part of the evaluation process. View parents as allies in the evaluation process.	Welcome the opportunity to learn what families think of the EI services offered, and use that information to improve the quality of the program. Remember that parents should be included in all parts of the evaluation process, from goal-setting to change implementation.

because parents rarely have a standard against which they can compare the services they do receive to those that they might receive. Instead, program evaluators must have a clear understanding of the services that families value, as well as the outcomes that they view as important.

Simeonsson et al. (1996) argued that rather than first gathering information about child and family characteristics, needs, resources, and priorities, professionals should first seek to understand families' expectations for the program. Sharing what they expect to receive from the EI program provides parents and providers an opportunity to clarify at the outset what is feasible and what is not. For example, in McWilliam et al.'s (1995) study, a source of dissatisfaction for families was the discrepancy between what services they expected and what actually was available within the community.

Only by gathering specific details can we gain insight into exactly what features of EI services families believe are beneficial (McWilliam et al., 1995, Wesley et al., 1997). In addition, Bailey (2001) and Brotherson (2001) call for programs to develop partnerships between families and professionals whereby families are involved at all stages of the evaluation process, from determining what will be evaluated to implementing evaluation efforts. As the results of the study conducted by Wesley and her colleagues indicated, engaging parents in the evaluation process can shed valuable and meaningful insights into how programs might better support families.

Involving Families in Evaluation Efforts

Strategies to engage families in evaluation efforts can be as diverse as the families themselves. Program staff can work together with their parent advisory board, and hold a number of different focus groups— group interviews facilitated by parents that give everyone an opportunity to talk about what they like about the program and what they want to see changed. When it is difficult for some parents to participate in a group interview, parent representatives of the program can conduct telephone surveys. Reviewing families' IFSPs to look for progress towards meeting goals would be an additional strategy. These are just some of the ways to learn about how a program is doing at meeting families' needs.

In this article, we have attempted to present the different ways in which program evaluations can seek to understand parents' perceptions regarding the delivery of EI services and how specific information can increase policymakers' knowledge of what parents value and expect from EI services. Figure 1 provides some guidelines that EI program administrators might find useful as they conduct program evaluations that are not only focused on families' needs, but that also incorporate families into the evaluation process.

It is clear that without a common perspective as to what constitutes effective services and important outcomes, any program evaluation effort will be compromised. As Bailey (2001) asserts, the field of EI must work toward some kind of clear statement of desirable family outcomes in order to determine whether high-quality services are being delivered. In an era of accountability, programs must be able to document how family-centered practices have resulted in valued changes for children and their families (Brotherson, 2001). Not only is it important to assess the degree to which services result in meaningful outcomes for children, it is also essential to understand how participation in an EI program results in positive outcomes for families.

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COLLABORATIVE PROGRAM EVALUATION:

Hawai'i's Experience With Early Intervention Services

TALETHA M. DERRINGTON
and
BEPPIE J. SHAPIRO
Center on Disability Studies, University Center for Excellence in Developmental Disabilities, University of Hawai'i at Manoa

PHOTOS: JANET BROWN MCCRACKEN

In 1986, Congress enacted Part C (then Part H) of the Individuals with Disabilities Education Act (IDEA) to provide early intervention (EI) services to children with special needs from birth to age 3. The state of Hawai'i acted quickly to construct a statewide EI service system for an ethnically, linguistically, and geographically diverse population. A broad definition of eligibility was adopted, and full implementation began in 1990.

At that time, very few studies had scientifically established that early therapeutic intervention can improve children's developmental outcomes. The enactment of Part C was largely based on hypothesis, rather than confirmed knowledge. Now, we have evidence that we can intervene successfully in young children's lives (e.g., Becker, Grunwald, & Brazy, 1999; Brooks-Gunn, Klebanov, Liaw, & Spiker, 1993; Gunnar, 1996; Guralnick, 1997; Infant Health & Development Program, 1990; McEachin, Smith, & Lovaas, 1993; Shonkoff & Meisels, 2000; Shonkoff & Phillips, 2003; Sonksen, Petrie, & Drew, 1991; and Whitehurst, Fischel, Caulfield, DeBaryshe, & Valdez-Menchaca, 1989); however, there remain many tenable yet untested hypotheses about specific benefits of EI and the design of effective EI service systems. Current research aims to evaluate these hypotheses and to demonstrate and validate methods to improve practice.

This article describes Hawai'i's experience planning and implementing a systematic evaluation of our EI service system. The evaluation has been a collaboration between the state Department of Health, the University of Hawai'i Center on Disability Studies (a University Center on Excellence in Developmental Disabilities Education, Research and Service), and other EI stakeholders. Given the current political emphasis on collaboration, accountability, and evidence-based practice, this example may provide insight to others with similar ambitions.

at a glance

- We have evidence that we can intervene successfully to improve children's developmental outcomes, but many hypotheses about specific benefits of EI remain untested.
- A feasibility study, assessing the data and methods available to answer questions of interest, can prevent commitment of significant resources to an overambitious agenda.
- Well-documented evidence of unmet need can provide support for additional capacity and for efforts to improve specific elements.

What Do We Want to Know, and How Can We Find Out?

Originally, our goal was to evaluate both the impact of EI on child and family outcomes and the system characteristics responsible for those outcomes. We received ongoing guidance from an advisory board of stakeholders, including parents of children with special needs and professionals in EI and related systems. The first issues we addressed were: 1) What questions should we ask? 2) What information do we need to answer these questions? 3) Where can we get it? and 4) How much time, effort, and money will be required? We launched a feasibility study, funded by the U.S. Department of Education Office of Special Education Programs (OSEP), to find the answers.

To identify the important questions, we reviewed literature, consulted national and local experts, and convened focus groups of parents whose children were served in EI. The result was a long list of questions and the information needed to answer them. We obviously needed to select a more manageable set of questions. As a first cut, the advisors eliminated many questions that exceeded our resources and decided to focus on children with or at biological risk for developmental delay.

Information needed to answer some questions was readily available. However, many questions remained for which information was potentially but not readily available. So, we set out to investigate whether and how we could answer these questions. We reviewed the state EI tracking system and met with EI staff from around the state to find out what information was kept and where. We reviewed local program records for individual children to determine the location, quality, and completeness of needed data — for example, demographic factors, evaluation dates, and results. Our stakeholders helped us access data and make sense of what we found.

The feasibility study helped us assess our evaluation capacity. It indicated that available methods and data for evaluating EI impact on child outcomes were weak. Our advisors had discovered a lot about the variability in program practice during 2 years of data collection and discussions about what might make programs effective. We had learned how complex answering even simple questions could become. Had we relied on administrators' and policymakers' initial impressions, we might have committed significant resources to an ill-fated, over-ambitious agenda. Had our feasibility study indicated adequate capacity to address the original goal of evaluating the impact of EI on child and family outcomes, our time and effort would have been well-spent in determining exactly what data we needed and where to find it. In our case, however, knowledge of our limited capacity and the complexity of our questions prompted the advisors to recommend a series of separate evaluations of system components. These were critical first steps towards a useful evaluation of the EI service system.

The advisors considered the various EI system components: service delivery, child and family outcomes, and Child Find, which refers to the identification and referral of potentially eligible children. Advisors decided to focus on Child Find, and we initiated a second OSEP-funded collaboration to evaluate Child Find.

Evaluating Child Find

The Child Find evaluation addressed five major questions as they apply to Hawai'i:

1. Are identification and referral equitable across demographic groups of interest?
2. Once children are referred, how timely is their progress through the stages of family contact, eligibility determination, and enrollment?
3. How friendly is the identification and referral process for families and referring professionals?
4. How much do professionals who could potentially refer children know about EI? and
5. Are we missing eligible children, and if so, why?

Equity refers to whether children from different groups are referred, assessed, and enrolled for services at the same rates. To evaluate equity, we collected referral and enrollment information for 5 subgroups: low income, immigrant, limited English ability, military, and homeless. We compared the proportions of these groups in the EI data to census population data and found that referral to and enrollment in EI is equitable for the first 3 groups, but not always for military families, who may be referred less frequently than census figures would predict. To our surprise, we could not evaluate equity for homeless children because programs do not systematically record homelessness, a variable not investigated during the feasibility study.

The evaluation of timeliness involved examining progress through referral stages in relation to IDEA federal guidelines, which require programs to make initial contact with families within 2 days of referral and to create the Individualized Family Service Plan (IFSP), based on an evaluation, within 45 days of referral. We collected data at 7 local programs randomly selected from the 22 programs that allowed us to access intake records. A total of 266 intake records were examined for children referred between January 1, 1994, and June 30, 1996. Of these referrals, 62.2% of initial family contacts were timely, 73.3% of evaluations were timely, and 62.4% of the IFSPs were timely. These figures indicated that the EI system could improve timeliness.

The third evaluation question, about system friendliness, was addressed by two methods. We collected information for 136 sequential referrals and conducted phone interviews with families of children referred to 5 program sites selected for geographic diversity. Interviews took place at different time intervals from referral (i.e., 1–3 weeks, 3–5 months, over 1 year). Second, we conducted a statewide survey of pediatricians, family physicians, hospital nurses, hospital social workers, day care and preschool teachers, home visitors, and public health nurses. Surveys were sent to all physicians on statewide lists supplied by pediatric and

family practice professional organizations (n = 261); to professionals randomly selected from lists provided by supervisors for home visitors (n = 95); social workers (n = 49); public health nurses (n = 33); to hospital nurses to whom supervisors agreed to distribute surveys in wards that served young children (n = 428); and for all day care and preschool teachers who worked with infants and toddlers under age 3, surveys were distributed to all programs serving children from birth to 3, to all programs serving children from age 2 on the islands other than O'ahu, and to a random sample of half of O'ahu centers serving children from age 2 (n = 314; overall N = 1180). The overall return rate was 72%, with a range of 56% (hospital nurses) to 92% (home visitors).

Hawai'i's Child Find system had missed about 25% of children with significant special needs born from 1991-1994. Two-thirds of the parents of these children had raised a concern with their primary care physician and had been advised to "wait and see".

The interviews and survey asked those who had experience with EI about system friendliness. The results suggested system friendliness is not a concern in Hawai'i; over 90% of families rated the EI system as "friendly" or "very friendly," and about 80% of professionals rated system friendliness as "good" or "excellent."

The provider survey also addressed the fourth question: How much do potential referrers know about EI? Results indicated that these professionals did not have adequate knowledge of the EI service system. For example, EI services are provided at no financial cost to families, but only 19.1% of respondents knew this (range from 5.6% for family physiciains to 30.8% for public health nurses). Eligibility categories were understood by only 56.7% of responding professionals (range from 46.2% for hospital social workers to 69% for home visitors). Finally, when asked where professionals would refer a child for an evaluation or services if they suspected a developmental delay, respondents listed places within the EI system only 32.6% of time.

To address the final question of whether all eligible children received EI services, we examined rosters of children ages 3 to 8 in special education. We selected children who were receiving services for a significant disability (e.g., Down syndrome, deafness) or who were receiving two or more related services (e.g. physical and occupational therapy). We believe that these children had special needs that could have been identified before age 3. We compared this list to the list of children in the same birth cohorts who were served in EI. If a child did not appear on the EI list, we attempted to interview the child's parents to determine why the child was not served by EI. Families of 91 children were interviewed over the phone (41% of non-matched records). Of these, 21 were not resident in Hawai'i before the child was 2.5 years old. Over 60% of the 70 resident families had indeed been missed by early intervention Child Find.

To the distress of our advisors and other interested groups, our results were far worse than anticipated. Extrapolating to the families who could not be contacted, did not respond to contact, or refused interviews, about 25% of children with significant special needs who were born from 1991 to 1994 had been missed. Of these parents, 65% had raised a concern to the primary care physician who either advised the family to "wait and see" or was not concerned. Another 15.6% of primary care physicians acknowledged the concern but took no action on behalf of the child and family, so about 81% of these children could have been identified and referred by their primary care physician but were not.

Evidence-Based Improvement of Child Find

That approximately one quarter of children with significant special needs were being "missed" by the Hawai'i Child Find system was alarming. Because Hawai'i's Part C eligibility criteria are broader than those used in the evaluation, we were undoubtedly missing even more children with less obvious needs. The lost chance to intervene when the biological and socio-cultural windows of optimal intervention opportunity open can have long-term negative impacts on the educational and justice systems, not to mention the incalculable loss of human potential for these children and their families.

Hawai'i Part C administrators presented this evidence of unmet need to Department of Health (DOH) policymakers and the state legislature. Policymakers were already aware that the present EI system was overloaded; if more children were to be identified and served, the service system would need additional resources. The evaluation results provided the needed support for additional EI capacity. In fact, from 1997 to 2001, the proportion of the state birth cohort served by EI due to developmental delays increased by 50% (2.4% to 3.6%). The evidence also inspired efforts toward improving the timeliness of referral, and data for fiscal year 2000 indicate that 96% of family contacts and 92% of IFSPs were completed within federal timelines.

The evaluation data also inspired a third collaborative effort between DOH and the University of Hawai'i, funded again by OSEP, to improve Part C Child Find. Again, the advisory board helped prioritize and focus this collaboration. The finding that potential referrers lacked important knowledge about EI suggested one avenue toward addressing this problem. Advisors reasoned that primary care physicians were likely to see more infants and toddlers on a regular basis than any other professional group. These observations coalesced into Project SEEK: Strategies for Effective and Efficient Keiki (Child) Find, to improve outreach to pediatricians and family physicians.

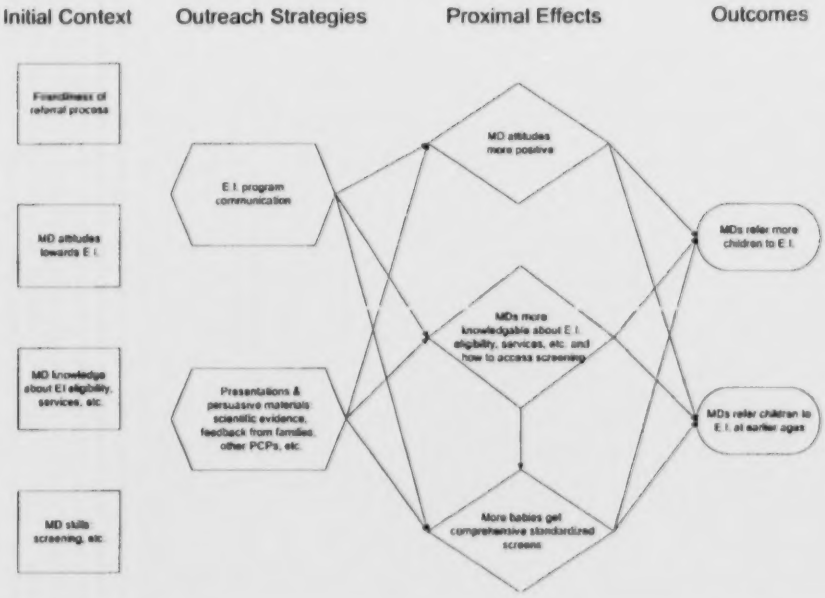
The results of the Child Find evaluation allowed us to construct a logic model for provider identification of children with potential special needs. The logic model guided the outreach design and created a framework to evaluate its effectiveness. Diagramed in Figure 1, the model predicts that as primary care physician knowledge and positive attitudes regarding EI increase, so do the number of referrals to EI, while the age at referral should decrease.

The evaluation framework called for measurement of changes in primary care physician knowledge and attitudes towards EI and in the number of referrals primary care physicians make. We established a pre–post design with intervention, comparison, and post-only comparison communities of primary care physicians[1]. Our measurement tools were a 33-item survey of knowledge, attitudes, and skills regarding EI, a count of the number of referrals, and the average child age at referral for each primary care physician. To predict sustainability, we planned to evaluate the efficiency of the strategies by recording resources spent in implementation.

We tried two different outreach strategies to increase provider knowledge and enhance positive attitudes towards EI. The first involved delivering informational and promotional presentations to primary care physicians. The presentation and accompanying materials addressed the knowledge and attitudinal barriers documented by survey responses. We addressed the knowledge barriers by providing information about cost, eligibility, and where and how to refer; we addressed negative attitudes toward EI through parent quotes about the benefits of EI and literature reviews on the effectiveness of EI and on early predictors of later delays. The second strategy included the same presentations and materials but also augmented communication between EI programs and primary care physicians. We worked with program staff to increase communication frequency and enhance the communications with selected facts about EI referral, eligibility, and benefits. For example, when a child was referred, the program would send a "Notice of Referral Status" to indicate whether the family had accepted or declined an evaluation, or if the program was unable to contact the family. This form listed Hawai'i's eligibility criteria at the bottom. Communications were created for each step from referral to discharge.

The outreach evaluation provides a good example of why evaluation is important: You may have a logical, reasonable program that is carefully designed and based on evidence, but it may not work in the way you think it will! In our case, the logic model assumes provider knowledge and attitudes mediate change in the number of referrals and age at referral. Preintervention data supported part of this model: We found significant, moderate correlations between knowledge and attitudes, as measured by the survey, and number of referrals. However, there was no systematic relation between the surveys and age at referral, so the prediction that provider knowledge and attitudes would mediate changes in age at referral was not supported.

FIGURE 1: IDENTIFYING CHILDREN WITH SPECIAL NEEDS


Initial Context
Outreach Strategies
Proximal Effects
Outcomes
Friendliness of referral process
MD attitudes towards E.I.
MD knowledge about EI eligibility, services, etc.
MD skills screening, etc.
E.I. program communication
Presentations & persuasive materials: scientific evidence, feedback from families, other PCPs, etc.
MD attitudes more positive
MDs more knowledgable about E.I. eligibility, services, etc. and how to access screening
More babies get comprehensive standardized screens
MDs refer more children to E.I.
MDs refer children to E.I. at earlier ages

[1] We included a post-only comparison group to take into account the possibility that the act of filling out the survey was an "intervention" for the comparison group and could affect their answers on the post-surveys.

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And, results for the presentation-only strategy indicate that the intervention community primary care physicians did not do much better than comparison community primary care physicians on the post-surveys of knowledge and attitudes (survey collection is underway to evaluate the presentation and communication strategy). Thus our logic model would have predicted no changes in referrals.

However, the difference in referrals following the presentation strategy is striking! Eight of 13 intervention group primary care physicians showed an increase in referrals per quarter ($M = 0.826$, $SD = 1.415$). Five increased by one or more standard deviation ($SD = 1.067$, calculated from 4 years of referral data for all study primary care physicains in practice during that period). The other 3 primary care physicians increased from 0.25 to 0.73 standard deviations. The overall pre- to post-intervention increase is statistically significant for this group (Wilcoxon Signed Ranks Test, $Z = -1.785$, $p = 0.37$ [1-tailed]; effect size = 0.652). The picture is quite different for the comparison group primary care physicians, where not one of the 9 primary care physicians made more referrals ($M = -0.339$, $SD = 0.586$). There was a significant, moderate association between group and change in referrals, with an increase in referrals associated with intervention group membership (Spearman's rho = 0.530, $p < 0.01$ [1-tailed]; effect size = 0.710). Preliminary data for the presentation and communication strategy indicate a similar pattern.

Evaluating the sustainability of these strategies was very important. Although we did reach 30 of 35 intervention community primary care physicians, doing so was very labor intensive. However, the positive impact on referrals suggests it might be worthwhile to modify the strategy by delivering a series of shorter presentations over more time. In addition, materials could be presented at different venues (e.g., hospital grand rounds).

The enhanced communications between EI programs and primary care physicians regarding the status of their referred and enrolled patients appeared to be readily sustainable. In fact, since project implementation ended, programs have continued to send modified versions of these communications. As of August 2002, programs had sent 214 communications, which is 66% of the number sent during focused implementation by Project SEEK staff.

How can we account for the failure of our logic model? Our outreach did have a positive impact, but the logic model was inaccurate regarding the role of knowledge and attitudes as measured by our surveys. The fact that increased knowledge about and enhanced positive attitudes toward EI do not appear to mediate increased referrals suggests that either the survey was not a good measure or that some other factor lead to change in referrals. For example, the increased contact between EI personnel and primary care physicians might have been the mediating factor. Future improvement efforts or generalizations to other provider groups should examine alternative hypotheses about mechanisms of change, new measurement strategies, or both.

Hawai'i's effort provides a concrete example of a collaborative program improvement process incorporating systematic evaluation. In the process, we learned valuable lessons!

- Convene and nurture a group of involved stakeholders. Give them substantive decisions to make and listen closely to their advice. They will be your best advocates.
- Look before you leap — figure out what you need to know and what it will take to collect data to answer questions or make decisions.
- Examine your assumptions — a logic model is a great way to clarify thinking and make underlying assumptions visible.
- Systematically evaluate change efforts — examine the links in your logic model that are not justified by definitive research; you may learn more than you expected.

Systematic program evaluations reduce reliance on unfounded claims and provide opportunities to test hypotheses regarding interventions, outcomes, and mechanisms of change. The net result is to increase established knowledge of evidence-based practice, and thus improve services for young children and their families. Hawai'i's evaluation led to notable EI system improvements, and set the stage for future progress toward optimal services for children with special needs and their families.

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- Psychotherapy for Young Children Exposed to Violence

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Research Plenary – Frontiers of Science: Research on Autism
This special plenary session will describe specific research efforts focused on the study of the etiology, early diagnosis and treatment of autism.

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- Early Literacy and Early Relationships
- A New Tool to Assess Father Inclusion Efforts in Programs
- Psychopharmacology for Young Children
- Addressing Maternal Depression

Sunday, December 7th
Practice Plenary - The Zero in "Zero to Three": Outreach and Continuity with Families in Pregnancy, at Birth and Beyond
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You can register quickly and easily on-line at www.zerotothree.org, or mail or fax the enclosed 2-page form. Please indicate your order of preference for each Field Presentation/Symposia time slot. These sessions will be ticketed. You will receive registration confirmation by fax or mail.

Purchase Orders—If you are paying by purchase order, please note that the check must be received in the registration office by November 15.

Cancellation Policy—Cancellation of registrations must be submitted in writing by mail or fax. Any cancellations received or postmarked by November 15 will be refunded, minus a $35 administrative fee. No refunds can be made after November 15. Registrations may be transferred to another person at any time; transfer requests must be submitted in writing by the original registrant.

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❑ Check here if you have special needs that require accommodation in order for you to fully participate. ZERO TO THREE encourages and welcomes all who work with infants, toddlers and their families to NTI. A member of our staff with contact you prior to the conference to make appropriate arrangements for your participation.

OVER ➤

Field Presentations/Symposia Selections

Please mark your first, second, and third choice in each time slot.

Friday, Dec 5
11:00 am – 1:00 pm

_ (A1) Field - The Power of the Relationship...Treating Traumatic Bereavement
_ (A2) Field - An Introduction to Reflective Practice
_ (A3) Field - Lessons from the Field: Mental Health...Early Head Start
_ (A4) Field - New Perspectives on Parenting Education
_ (A5) Field - Implementing Continuity of Care
_ (A6) Field - Teaming for Success...Cultural and Linguistic Relevancy
_ (A7) Field - Lessons from Ground Zero
_ (A8) Sym - Issues in Child Welfare (Part 1)
_ (A9) Sym - DIR...Assessment and Intervention
_ (A10) Sym - Observation, Reflection, and Discussion

Friday, Dec 5
2:30 pm – 4:30 pm

_ (B1) Field - Sierra's Secure Base
_ (B2) Field - IMH in Early Head Start
_ (B3) Field - Resiliency and Relationship-Based Intervention
_ (B4) Field - Vital Links...Families, Health Care, and Early Intervention Providers
_ (B5) Field - Positive Interventions with Parents Who Have Cognitive Limitations
_ (B6) Field - Addressing the Complex Needs...Foster Care
_ (B7) Field - Crossing the Bridge from Research to Practice
_ (B8) Sym - Temperament
_ (B9) Sym - Focus and Reflect
_ (B10) Sym - Psychotherapy For Young Children Exposed to Family Violence

Saturday, Dec 6
11:30 am – 1:30 pm

_ (C1) Field - Stressed Families: The Impact of Homelessness
_ (C2) Field - Supervision as a Vehicle for Supporting Staff Development
_ (C3) Field - Attachment Disorders in Maltreated Twins
_ (C4) Field - Communities of Practice...Building the Evidence Base
_ (C5) Field - Reaching Out to Young Children At-Risk
_ (C6) Field - The Action Is in the Interaction...Family Dynamics
_ (C7) Sym - An Introduction to the CLNBAS
_ (C8) Sym - Good Night Moon and Beyond: Early Literacy Experiences...
_ (C9) Sym - Issues in Child Welfare (Part 2)
_ (C10) Sym - An Assessment Guide on Father Inclusive Practices

Saturday, Dec 6
3:15 pm – 5:15 pm

_ (D1) Field - Useful Tools for Helping...with Distress
_ (D2) Field - Experiences in Providing IMH Services
_ (D3) Field - Changing Policy and Practice...the Judicial and Child Welfare Systems
_ (D4) Field - Innovative Strategies for Personnel Development
_ (D5) Field - A Year of Treatment for a Toddler with Autism
_ (D6) Field - Music Therapy and Early Intervention
_ (D7) Field - Fetal Alcohol Syndrome
_ (D8) Sym - Psychopharmocology for Young Children
_ (D9) Sym - Examining Cultural Themes in Parenting Strategies
_ (D10) Sym - Addressing Maternal Depression

Hot Topic Networking & Discussion Groups

Please select 3 topics of interest to you. A total of 6 topics will be selected from among those most popular with NTI registrants.

❑ Assessment/Screening
❑ Attachment
❑ Autism/Autistic Spectrum Disorders
❑ Breastfeeding/Feeding Issues
❑ Child Abuse Prevention/Treatment
❑ Child Welfare
❑ Culture/Diversity
❑ Early Brain Development – Training
❑ Early Brain Development – Uses of Research
❑ Early Literacy
❑ Evaluation/Quality Improvement
❑ Inclusion/Natural Environments
❑ Infant Mental Health – Practice
❑ Infant Mental Health – Systems
❑ Infant Mental Health – Training
❑ Infant/Family Program Leadership
❑ Male Involvement in Infant/Family Programs
❑ Observation
❑ Parent-Child Relationship Building
❑ Policy/Advocacy
❑ Reflective Supervision
❑ School Readiness
❑ Training - Distance Education
❑ Training – Pre-service & In-service
❑ Trauma/Child Witness to Violence
❑ Welfare-to-Work

Tell Us A Little About Yourself

Please share your discipline and background with us so that we can better meet your needs!

A. Your Profession
❑ Child Psychiatrist
❑ Early Childhood Educator/ Child Care Provider
❑ Early Intervention Provider/Special Educator
❑ Family Support Worker
❑ Nurse
❑ Occupational Therapist
❑ Parent Educator
❑ Pediatrician
❑ Physical Therapist
❑ Psychologist
❑ Social Worker
❑ Speech Pathologist
❑ Other (specify)
_____

B. Your Primary Job Function
❑ Administrator
❑ Child/Family Advocate
❑ College/University Faculty
❑ Direct Service Staff
❑ Home Visitor
❑ Parent
❑ Private Practice Consultant
❑ Service Coordinator
❑ Supervisor/Manager
❑ Training/Technical Assistance Provider
❑ Other (specify)
_____

C. The Setting/Area In Which You Work
❑ Child Care/Early Care Home-based
❑ Child Care/Early Care Center-based
❑ Child Welfare/Foster Care
❑ Early Head Start
❑ Early Intervention
❑ Family Support
❑ Hospital
❑ Judicial System
❑ Mental Health
❑ Primary Health Care
❑ Private Practice
❑ Social Service/ Community Agency
❑ University/College
❑ Other (specify)
_____

D. Your Years in Practice
❑ 1
❑ 2-3
❑ 4-7
❑ 8-10
❑ More than 10

E. Your Highest Educational Level
❑ High School Diploma
❑ Associate Degree
❑ Bachelor's Degree
❑ Master's Degree
❑ Doctoral Degree
❑ Other (specify)
_____

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PARENTS KEEP OUR EYES ON THE PRIZE:

Monitoring Early Intervention in Massachusetts

RON BENHAM, PATTI FOUGERE, FAITH PIAGGI,
and
KATHARINE THOMAS
Massachusetts Department of Public Health

Like every state, Massachusetts monitors its 64 early intervention (Part C) programs for infants and toddlers with disabilities. A recertification team of regional disability specialists and licensure staff visits each early intervention site every other year. In September 2001, Massachusetts added new members to its recertification team: parents of children who have graduated from Part C programs. "Parents keep our eye on the prize of the family-centered nature of the early intervention services," says Katharine Thomas of the Massachusetts Department of Health, the state lead agency. She notes that including parents on the team helps to ensure that programs are not only following the letter of the law, but also fulfilling the full intent of the law.

Like well designed and executed program evaluations, the Massachusetts early intervention monitoring process aims toward continuous improvement. Although the recertification process might, in the past, have suggested the image of an inspector with a checklist, the current process is designed to gather qualitative as well as quantitative information from many stakeholders. When the team discovers areas of concern, it recommends improvements and provides technical assistance.

The Massachusetts monitoring process uses focus groups to complement other data. The team organizes four focus groups at each site for early intervention staff, administrators, community providers, and parents. Each group is asked a set of questions based on the requirements of the Individuals with Disabilities Education Act (IDEA). Questions address outreach activities, the timeliness of Individualized Family Service Plan (IFSP) development, family-centered care, transition planning, and self-assessment. Parents are asked specifically whether they have complained about non-provision of services or other concerns, as well as how the program has been helpful to their family.

The parent member of the recertification team, trained in focus group facilitation and other communication skills, frequently conducts the parent focus group at each site visit. As parent members become more comfortable with the process, they may also facilitate the staff focus groups and others. In May or June of each year, all of the parent recertification team members meet with a regional specialist. They review their experiences with scheduling, facilitation, and training, and make plans for the coming year.

What does a parent on the monitoring team add to the recertification process? According to state agency administrators, parents offer valuable feedback about the quality of

early intervention services, raise administrators' awareness of families as primary consumers and partners in early intervention, and offer an ongoing commitment to the families they encounter. Both parents and staff members at sites seem to speak more freely to a parent than they might to an administrator. When the time to share findings and recommendations arrives, staff seem more willing to hear a suggestion or concern from a parent. Parent team members have relayed parent concerns about potentially stressful activities for families, such as the need for family-centered language in IFSP development and careful planning and implementation of transitions. They have also relayed the concerns of parents who find that the policy mandating provision of services in natural environments has actually reduced their opportunities to meet other parents of young children with disabilities.

How do parents view their participation in the recertification process? Parents report that they feel valued. They can see that other team members take their comments into account, and they view their involvement in the recertification process as good evidence that the Department of Health genuinely wants to include parents at many levels of the early intervention system. Parents enjoy the overview of the statewide early intervention system; particularly those who have not been outside their own local system before joining a recertification team. Many parents find participation a good training opportunity; they learn information and skills that help them in their professional lives.

With its team approach, focus groups, and use of trained parents, Massachusetts has added elements of qualitative research to its recertification process, adding texture and context to quantitative information. When parents are part of the monitoring team, program participants and staff members find it easier to talk about their concerns—and to listen to ideas for addressing them. ♦

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CALIFORNIA'S PROPOSITION 10 AND LOCAL EVALUATION:

A County-Level Report from the Field

MARC R. THIBAULT
Sr. Vice President, Corporation for Standards & Outcomes
PABLO A. STANSBERY
Sr. Evaluator, Harder+Co
LINDA A. WOLLESEN
Home Visitation Training Consultant

"Outcome-based accountability" is a key feature of the California Children and Families First Act of 1998, also known as Proposition 10 (Friedman, 2000). This voter-approved initiative imposed additional taxes on cigarettes and tobacco products. Tax-generated revenues (expected to amount to as much as $700 million each year) are distributed "for the purpose of promoting, supporting, and improving the early development of children from the prenatal stage to five years of age" (California Health and Safety Code Section 130100). Proposition 10 established a State Commission (now called First 5) for statewide education and outreach, and to provide oversight and technical assistance to locally created Commissions in each of California's 58 counties. County First 5 Commissions must develop community-driven strategic plans. Local programs must define expected outcomes before they are funded. Once funded, they must collect data to measure progress toward achieving those outcomes.

Outcome-based accountability under Proposition 10 represents a significant departure from earlier mechanisms for funding and evaluating child and family services in California. Historically, services for infants, young children,

and their families in the state have been funded primarily through categorical systems—for example, child care subsidies, child welfare programs, and early intervention. State and federal agencies have made annual grants to county programs and contracted community organizations to set practice standards. Evaluation, typically linked to each grant, consisted largely of establishing process goals and collecting data on clients served. University-based evaluators might have little relationship to local service providers.

This article describes some of the rapidly evolving local implementation and community-based evaluation experiences that are emerging from Proposition 10. The authors include a database management consultant, a contracted local evaluator, and a local provider or outcome tool designer. Each assists a number of County Commissions in the implementation and evaluation of their local Proposition 10 initiatives.

An Overview of Proposition 10 and the Role of Evaluation

Proposition 10 was established to address issues of children's health, family support, school readiness, and system change. The legislation requires distribution of tobacco tax revenues according to a set formula: 80% of funds are distributed proportionately among County Commissions based on county birth rates; 20% of revenues go to the First 5 State Commission for public education, technical support, oversight, and evaluation. Funding under Proposition 10 is intentionally non-categorical and flexible, allowing County Commissions to fund a wide range of efforts within the framework of a formal strategic plan developed with extensive community input. The key component of Proposition 10 is its mandated use of an outcome measurement approach to evaluate the impact of services and systems on children from before birth to age 5 and their families.

To achieve community consensus on the priorities that shape the strategic plan, County Commissions have reached out to gather the opinions of a broad range of stakeholders, including parents, community organizations, county agencies, the education and medical communities, and other groups. When fully implemented, the strategic plans help to frame an overall evaluation process that allows local Commissions to answer six major questions:

1. What are the Commission's **priorities**, investments, and strategies?
2. Do they achieve their intended results in **measurable** ways?
3. How do they **make a difference** in the lives of children and families from diverse backgrounds?
4. Are they **impacting the system of services**?
5. Can they be **duplicated** in future years?
6. Can they be **sustained**?

To provide a coherent structure at a statewide level, Proposition 10 identified four goal areas to guide the development of County Strategic Plans. These include:

- Improved Child Development
- Improved Child Health
- Improved Family Functioning
- Improved Systems for Families.

The challenge for local Proposition 10 program managers, evaluators, and local data system staff has been to ensure that each funded program's outcomes map to at least one of the goal areas.

Organizing a Data Collection Methodology to Assist Local Evaluation

Under Proposition 10, each County Commission has created a local team to implement outcome-based evaluation, driven by the local strategic plan. Teams include Commission staff, grantees, evaluators, and data collection specialists. Proposition 10-funded programs tend to use a similar evaluation process once they have made the shift to an accountability model. Programs:

- **Pinpoint specific indicators** that link directly to their county's strategic plan and measure the impact of their programs,
- **Review existing data collection efforts** as well as **alternative** assessment tools that capture the impact of each measurable outcome,
- Establish an **evaluation timeline**, and
- **Train staff** to reliably employ the selected data collection and evaluation tools.

Evaluation consultants can help Commissions and local grantee agencies develop their evaluation capacity, co-construct an evaluation design, and implement the design. Agencies contribute knowledge of their participants and service delivery to this process; evaluation specialists provide options for enhancing agencies' current evaluation efforts.

Many local Commissions have applied Results Based Accountability (RBA; Friedman, 2000) or other performance-based accountability methodologies (Centers for Disease Control, 1999; Patton, 1997). A major technology partner involved in Proposition 10 evaluation is the Corporation for Standards & Outcomes (CS&O). CS&O's Internet-based contract management and outcome measurement system is called the Outcomes Collection, Evaluation and Reporting Service (OCERS), developed specifically for Proposition 10 programs.

at a glance

- Outcome-based accountability is a key feature of California's Prop10/First 5 early childhood initiative.
- Each county's outcome-based evaluation is driven by its local strategic plan.
- Evaluation becomes a team effort when county Commission staff, evaluators, and service providers work together.
- Evaluation results will identify promising practices and guide program development.

Adopted by 13 local Commissions in response to the accountability requirement, the OCERS system was designed to track Commission investments and provide an unduplicated client database accessible through a secure Internet connection from a worker's office or, for example, on a laptop from a participant's home. The central database is used to derive a longitudinal comparison of the impact of one or more service strategies on individual participants or across whole groups of Proposition 10 clients in a county. OCERS helps to focus programs' attention on data collection and confidentiality.

Collecting data: As part of its role, the evaluation team identifies a core set of data elements that best defines the participants served by Commission-funded agencies. These core data elements are collected on all program participants who receive a funded service and authorize their data to be entered. Sample data include: participant demographics, comparative prenatal and birth outcome indicators, ongoing indicators related to health (e.g., consistent health coverage for the child or family), family support of the child (e.g., increased reading and storytelling patterns to encourage the child's brain development and school readiness), and other related outcome domains. To measure the results achieved, OCERS incorporates a small set of Project Level Questions (PLQ) for each funded indicator and strategy as designed by the evaluation team with grantees, and based on the latest research. The PLQs make evaluation easier for service providers who may have limited time and research experience. For example, a 5-point scale designed to measure parental knowledge of locally available resources could read, "Has the parent used locally available resources at least once in the past 3 months?"

Creating a confidentiality protocol: Each Commission has developed a data collection and data sharing protocol. These protocols and universal data sharing authorization forms are used to protect client confidentiality while meeting the special needs of the evaluation and research community and addressing the requirements of local Institutional Review Boards (IRB) and the Health Insurance Portability & Accountability Act (HIPAA).

Once defined, core data elements and PLQ are collected, using the approved Confidentiality Protocol, in an automated interview format at approved "snapshot" time intervals (e.g., every 3 or 6 months). Access to program-specific data is controlled by the user's login identification, which allows access only to the program data they are authorized to view.

Local Evaluation— An Evaluator's Perspective

Proposition 10's emphasis on performance measurement created important opportunities for research and evaluation contractors specializing in early childhood issues. County Commissions have engaged evaluation firms, university-based research centers, and individual evaluators to assist in designing and implementing evaluation frameworks for measuring the outcomes of provider agencies' efforts. Harder+Company Community Research, for example, provides consultation to more than 100 Proposition 10-funded programs in 10 counties. Evaluators serve as a bridge between diverse providers, with varying experience and sophistication in outcomes-based accountability; state and local Commission reporting mandates; and, where appropriate, systems like OCERS.

Proposition 10 sharpened the focus on outcomes in human services and provided resources to create much-needed links among service providers, evaluators, and data management consultants.

Examples of evaluation methods and service used by counties with diverse demographic characteristics include:

- Merced County used client surveys and provider interviews to evaluate the success of a government agency and its non-governmental partners in providing transportation and cultural brokerage services for families and children.
- El Dorado County used case study reports and parent focus groups to evaluate parent–child education classes provided by a school district and community center.
- Santa Clara County used interviews with community members and service providers involved in community partnerships to evaluate and report on the effectiveness of regional groups charged with defining and prioritizing local service needs.

Evaluation becomes a team effort when Commission staff, evaluators and providers work together to identify relevant data collection items, facilitate training in the data collection system, and test new confidentiality procedures—all so that they can aggregate information to meet outcome reporting requirements.

Local Evaluation— A Provider's Perspective

In most small California communities, service providers have had few opportunities to work with researchers or evaluators. Before Proposition 10, most service providers were required to report "process outputs," such as the number of contacts with clients in a given period, but they had seldom been asked to report what outcomes children and parents served were achieving. Proposition 10 sharpened the focus on outcomes in human services and provided resources to create much-needed links among service providers, evaluators, and data management consultants.

First 5 Monterey County, for example, developed an initial evaluation framework to guide the 20 agencies it funded to provide services ranging from child care and dental services to parenting education and violence intervention. The evaluation has had to consider a diverse group of providers, including small churches, non-profit organizations, and government agencies. The evaluation process has matured over

time. In 2002, the Monterey Commission hired an evaluation consultant and CS&O for data management. Working together, commissioners, committees, staff, and consultants have consolidated the list of local outcomes and clarified what is expected of grantees in regard to data collection.

The experience of the Monterey Home Visitation Service Collaborative —a "quilt" of related services that includes Early Childhood Education/Parents as Teachers, Early Start (IDEA), Early Head Start, and Public Health Nursing— illustrates the impact of an outcomes focus. The collaborative supported the design and use of a new parent–child outcome tool, The Life Skill Progression (LSP). Outcome data from the LSP helped the collaborative members secure funding from Proposition 10, a federal Safe Schools/Healthy Students grant, and an Early Head Start grant.

Linda Wollesen, a Public Health Nursing Supervisor, developed the LSP to obtain Proposition 10 funding for a Nurse Family Partnership (NFP/Olds) research replication site (Olds, 1998) in Monterey County. The LSP has since been piloted and used by all of the member agencies in the Monterey Home Visitation Service Collaborative (except Early Start, which requires infant assessment rather than screening). Programs complete the LSP at intake, every 6 months, and at closure. Clerical staff enter data into a centralized Access data program maintained at the Health Department, and outcome reports are generated for each program.

The LSP is a 43-item Likert scale, which sequentially measures both parent and child outcomes. It assesses parent skills in the areas of relationships and parenting, education and employment, maternal–child health, mental health and substance use, and basic needs. The child scales parallel the developmental domains of the Ages and Stages Questionnaire and the ASQ-Social-Emotional, and can be used to profile development, the use of special early intervention services, and the child's regulation characteristics. Brad Richardson of the University of Iowa-based National Resource Center for Family Centered Practice established reliability for the LSP at 90%. A ZERO TO THREE National Leadership Fellowship (2001) helped to support refinement of the LSP through multidisciplinary expert consultation and mentoring during a content validity study. Evaluator consultation for the LSP has come through a Federal Safe Schools grant (Public Health Institute and Prevention Institute) and from evaluators linked to eight Proposition 10 counties. Data management support came from Monterey County Information Technology and CS&O. In the future, as the use of the LSP expands to other sites and home visitation systems nationally, having a Web site with more sophisticated analysis capability for programs not funded by First 5 will be a logical next step and a good example of an impact of the First 5 initiative that reaches beyond California.

Examples of a Parent LSP Scale and an Infant LSP Scale are:

Parental Support of Development:

1. *Nonexistent or unrealistic expectations*. Lacks or refuses information.
2. *Limited knowledge of development limits or fails to encourage development*. Passive parenting role.
3. *Accepts developmental information*. Uses some ideas. Provides a few toys for age. Open to parenting resources.
4. *Seeks information regarding development*. Applies information learned. Notices child's development, skills and interests.
5. *Anticipates development* with age appropriate toys; enjoys playing with and reading to child.

Infant Communication

1. *Below Adjusted Age or Chronological Age* (AA/CA) and Early Intervention (EI) criteria. Referred to EI. Not enrolled or attending.
2. *Delays meet EI criteria*. Referred, enrolled, sometimes attends.
3. *Delays meet EI criteria*. Referred, enrolled, attends regularly. (3.5 emerging or regressing developmental delays but not meeting EI criteria)
4. *No delays*. Average development for AA or CA level.
5. *Above average development* for AA or CA level.

One example of impressive prevention outcomes emerged when ASQ-based LSP data showed that after 24–36 months of service, all of the low-income infants enrolled in the Proposition 10-funded Parents as Teachers program (N=130) showed average or above development for age.

Conclusions and Recommendations

Evaluation is not an endpoint, but a beginning. Local Proposition 10 Commissions are using evaluation to establish the infrastructure for a new way of providing services to very young children and their families. On a large scale, with a culturally diverse population, the evaluation process is being used to continuously inform strategic planning and enhance service delivery in collaborative environments. As more participant impact data becomes available, the growing pains associated with Proposition 10 will become milder. Evaluation results will guide program development and identify promising practices. Today, Commissions in large, medium, and less populated counties all have experience with the evaluation process. They are willingly contributing their expertise to other Commissions. Collaboration, a major goal of Proposition 10, is working.

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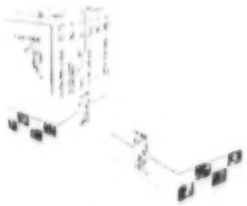

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3. ***Safe from the Start*** (with Gloria Estefan) — shows parents and caregivers how to keep children safe from accidental injuries. The video includes information on child safety seats, toy and gun safety, and provides practical advice to keep children safe both inside and outside the home.
4. ***Quality Child Care*** (with Maria Shriver) — focuses on the importance of finding quality child care and what to look for when choosing a care provider.
5. ***Discipline*** (with T. Berry Brazelton) — explains why children actually look for behavioral limits. It shows that a firm but gentle approach is best and demonstrates useful techniques to promote discipline. Dr. Brazelton also offers advice to help parents and caregivers manage their own emotions and avoid using physical punishment.
6. ***Your Healthy Baby*** (with Phylicia Rashad) — focuses on children's health and nutrition and on their changing health needs as they grow. It provides useful information on prenatal care, breastfeeding, visiting the pediatrician, children's nutritional needs, and exercise.

Parent Educator's Manual

Written by ZERO TO THREE's Claire Lerner, this manual ties together all six videos and offers a menu of activities from which the parent educator may pick and choose when planning a session with parents or caregivers. Guides to each of the six videos are featured, and ideas for additional learning activities are provided. A CD-ROM provides extensive handouts to help make the most of the video series. Educators will find the package useful in parent education classes, home-visiting sessions, train-the-trainer environments, or even in one-on-one sessions with parents.

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PHOTO: JESSICA KLEINMAN

EVERY CHILD COUNTS:

Creating a Community Holding Environment for Families With Young Children

DEBORRAH A. BREMOND
and
TEDDY MILLER
Every Child Counts, Oakland, California

In 1998, California voters passed the California Children and Families First Act, commonly known as Prop (Proposition) 10 (for a description of Prop 10, see Thibault et al., this issue p. 35). The legislation directs revenue from tobacco taxes to resources for children birth to 5 years of age and their families. Each county in California was charged with developing its own strategic plan, service system, and evaluation process. In December 1999, the Alameda County Children and Families Commission became the first commission in the state to have its strategic plan, Every Child Counts (ECC), approved. ECC's first challenge was to create, enhance, and implement a set of services while simultaneously developing methods for evaluating their effectiveness.

This article will describe ECC's efforts to work with neighborhoods, institutions, and systems as we move toward creating an integrated service delivery system for families with young children in our county. We will discuss the strategic planning process and development of ECChange, a Web-based information system, as a backdrop for understanding the context of ECC's role as a change agent; the challenges associated with being a change agent and with the change process; and the lessons learned since 1999. We will pay particular attention to the simultaneous interplay between program development and program evaluation.

at a glance

- Every Child Counts (ECC), supported by tobacco tax revenue, is trying to create an integrated service delivery system for families with young children.
- Home-based services, child care-based services, and support to community-based providers are designed to implement the county strategic plan.
- ECChange, the cross-agency, Web-based information system serves as a case management and accountability/evaluation tool.
- Agents of organizational change must "hold" programs while they are in a state of disequilibrium and individualize organizational interventions.

A Strategic Plan and an Accountability Framework for Alameda County

Alameda County, the seventh most populous county in California, has a population of 1.4 million people, of which 98,000 are children between birth and 5 years of age. More than 21,000 babies are born in the county every year. Almost all (98%) residents live in the county's cities or suburbs. County residents represent a wealth of ethnic, cultural, linguistic, economic, and geographic diversity.

The major elements of the planning process included: research into best practices, community outreach, infrastructure development, and strategic plan development.

In general, comprehensive community initiatives operate at many levels: individual, family, community, institutional, and system (Weiss, 1995). The ECC plan is anchored in the development and enhancement of community-based standards of care for providers serving families with young children. This theory of change supports and guides the integration of evidence-based and best-practice models into programs serving young children and their families. The community-based standards of care provide a benchmark against which ECC measures the quality and effectiveness of support offered to families.

To carry out the strategic plan, we developed three service delivery divisions—one for each environment:

1. Family support services (home-based services),
2. Early care and education (focused on child care settings), and
3. An innovative community grants initiative (support to community-based providers).

ECC uses multiple strategies to attain its goals, including:

- "Universal" services (offering 1–3 home visits to all families with newborns at each of four hospitals) and targeted services (for special populations such as medically fragile infants, pregnant and parenting teens, and families reported to Child Protective Services);
- Direct (services to families) and indirect services (e.g., working with child care providers around quality and environment issues); and
- ECChange, the cross-agency, Web-based information system that serves as a case management tool, informs the accountability framework (evaluation), and helps integrate ECC with its partner agencies.

Under Prop 10, each county in California must develop an accountability framework to measure the impact of services funded by Prop 10 resources. The ECC accountability framework, developed by the Evaluation and Technology division, includes: a confidentiality and privacy policy; a detailed cross-program outcome, indicator, and performance measure matrix (Milder, 2000); a technical assistance program to build local capacity for using outcomes-based accountability models; a qualitative evaluation component; and a technical infrastructure, ECChange, to measure and report outcomes.

In May 2000, we began to implement the strategies described in the ECC strategic plan. In July 2002, guided by our accountability matrix, we began the third year of data collection. The matrix provides a means of assessing progress and measuring the impact of interventions. We understood at the outset of our endeavor that the first 3 years would establish baseline information and create the quantitative and qualitative infrastructure to measure the impact of services, determine what is working, and, when necessary, use data to make mid-course revisions.

The Strategic Planning Process

After the passage of Prop 10, the Alameda County Board of Supervisors established a Prop 10 steering committee. The steering committee hired staff to lead the planning process. The major elements of the planning process included: research into best practices, community outreach, infrastructure development, and strategic plan development. Input for shaping the strategic plan was gathered from public hearings, telephone surveys, a parent advisory group, and responses to the ECC Web site and newsletter.

We identified four goals:

1. Support optimal parenting, social and emotional health, and economic self-sufficiency of families.
2. Improve the development, behavioral health, and school readiness of young children from birth to age 5.
3. Improve the overall health of children birth to age 5.
4. Create an integrated, coordinated system of care that maximizes existing resources and minimizes duplication of services.

The ECC strategic plan includes:

- 1–3 home visits for every baby born to an Alameda County resident;
- Intensive family support to medically and socially at-risk babies and families up to 3 years;
- A Child Development Corps that offer stipends to child care workers to improve retention and increase professional growth;
- Quality assessments of early care and education environments;
- Loans and grants to child care facilities;
- School readiness programs; and
- Grants to public and community organizations that meet ECC goals.

Moving Toward Integrated Services

In order to move forward on goal four, "create an integrated, coordinated system of care that maximizes existing

resources and minimizes duplication of services," we had to envision what "integrated services" would look like and how they would work.

First, we had to remember that the three service divisions (home, child care, and community) that we established to carry out the strategic plan overlap and are interdependent. We needed to address *this interdependence in how we* thought about and developed services and strategies.

We developed a comprehensive outcome-based accountability framework based on the strategic planning process. The ECC accountability matrix describes the specific programmatic strategies needed to implement our overall vision of improving the lives of children and families, then links the strategies to outcomes, outcome indicators, and performance measures that are used to monitor progress and measure impact. The matrix acts as a bridge between vision and programmatic details. Simply put, it is a tool for measuring how well ECC is achieving its vision.

Collecting the same data from all programs funded through Prop 10 presented ECC with an accountability challenge. Assuring the integrity of data collected by hospital outreach workers, public health nurses, social workers, family advocates, and community health outreach workers called for both innovative thinking and technology.

Assuring the integrity of data collected by hospital outreach workers, public health nurses, social workers, family advocates, and community health outreach workers called for both innovative thinking and technology.

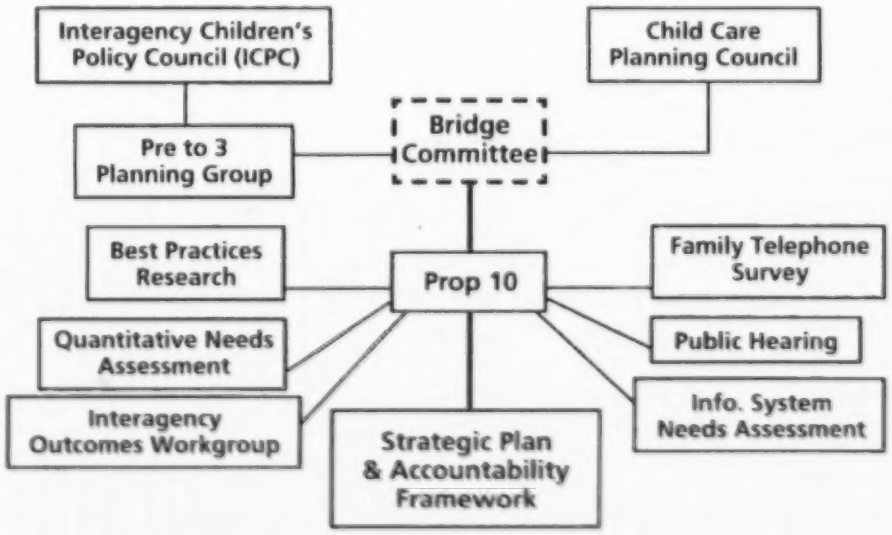
ECChange: A Web-Based Information System

To measure the results of integrated programs for children birth to 5 years and their families, we created ECChange, a Web-based cross-agency information system. Incorporating the newest technologies, ECChange allows authorized staff from private and public agencies in various environments and locations in the field to use the system; integrates with existing local, county, or state information systems; and automates existing paper forms. Locating the database on a secure private network on the Internet ensures ease of access from remote locations and allows easy transfer and receipt of information among collaborating agencies. ECChange data is protected by the strictest and most up-to-date security technology and meets the federal health privacy regulations specified by the Health Insurance Portability and Accountability Act (HIPAA).

ECChange helps ECC-funded service programs with their case management. It also informs the accountability framework mandated by Prop 10. ECChange's functions include:

- Electronically assisted hospital-based enrollment of newborns and families into ECC family support programs (universal and intensive family support);
- Electronic referrals to public health nurses;

FIGURE 1: SHAPING THE STRATEGIC PLAN



- Documentation of home-based family support services by public health nurses and family advocates in the field, using mini-laptops; and
- Management and reporting.

The development of ECChange included: performing a county-wide information system assessment; partnering with private, public, and non-profit organizations to develop specifications and data-sharing agreements; implementing a confidentiality and privacy policy; and building a platform-independent system that would serve the functional and reporting needs of all partnering agencies.

The team works closely with all three components of service delivery (family support services, early care and education, and community providers) to operationalize an integrated perspective on service planning and implementation.

The first step in the process was to establish a cross-agency work group that included representatives from social services, public health, medical managed care, hospitals, and other nonprofit and academic organizations. The work group selected, prioritized, and defined outcome indicators that, in turn, determined data collection needs. At the same time, ECC assessed the information needs of the agencies and providers throughout the county who would be providing ECC services. We also reviewed previous efforts at data integration in the county to understand why they had met with limited or no success.

Additional steps in developing ECChange included building an understanding to share information across agencies and developing a specifications document to select a vendor to build a platform-independent system. In a process that included professionals in both service delivery and information technology, ECC and ECChange created a user-friendly, collaborative process for agencies and programs to monitor productivity, generate reports, and measure the results of their work with families and young children. Using ECChange, ECC can now provide feedback to our partner agencies about indicators of effectiveness and outcomes.

In many ways, the Evaluation and Technology team is the soul of our efforts to collaborate and create integrated services across systems. The team works closely with all three components of service delivery (family support services, early care and education, and community providers) to operationalize an integrated perspective on service planning and implementation. A closer look at ECC Family Support Services illustrates this process.

Family Support Services

ECC works with 10 agencies in the county to provide direct services to families with young children. These agencies constitute ECC's Family Support services. All are accountable for reporting on the same outcomes and indicators. During the ECC planning process, we reviewed the published literature on family support best practices and evidence-based intervention strategies (Carrillio, 1998;

FIGURE 2: THE INTERDEPENDENCE OF SERVICES AND STRATEGIES

FAMILY SUPPORT SERVICES
Universal 1-3 plus 10 home visits for newborns and families
Intensive Family Support • Special Start • Teen Parents
Specialty Consultation Team • Alternate Response
Developed by Children's Hospital Oakland Consultation and Training Team
Diversity
Accountability
Cross-Disiplinary
Systems Integration
School Readiness
COMMUNITY GRANTS
Spruce up for Kids • Community Grants Initiative • Special Grants
EARLY CHILD CARE & EDUCATION
Child Development Corps • Career Advocates
Child Care Fund • Mentors • Family Child Care Fair

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Kagan, Powell, Weissbourd, & Zigler, 1987; Sameroff & Fiese, 2000). On the basis of this review, we decided to focus on integrating the following tenets and best practices into new and existing service delivery models:

1. Family-centered practice (Acknowledge the reciprocal nature of family well-being and child development and include support for the family as a whole);
2. Child development-focused services (Intervention places high priority on facilitating the healthy development of the child);
3. Relationship-based intervention (The family–provider relationship is the most important tool and is critical in working with families);
4. Multidisciplinary services (Incorporate the perspectives of different professional disciplines);
5. Reflective supervision/consultation for staff (Offer a process for operationalizing relationship-based services within the context of early intervention.);
6. Caseloads of 20–25 families per worker (Providers of intensive family support must have manageable caseloads).

These six program tenets are helping ECC create a common language among agencies and develop community-based standards of care in ECC-funded family support services. However, as programs of all types moved to integrate these practices and principles into their organizations, many experienced considerable organizational disequilibrium.

The programs selected to be core ECC service providers had experience in the community providing direct services to families before Prop 10. Programs ranged from grassroots community-based organizations with 20 years of experience to newly formed public–private partnerships. Some agencies or programs already embraced all six program tenets and had been working for more than 15 years to achieve integrated service delivery models. Some programs embraced one or two of the tenets but lacked the internal capacity to implement even these within their current service delivery models. Many programs resisted our brand of change. They perceived ECC requirements as "micromanagement." They saw requests to incorporate additional strategies into their existing service delivery models as a negative judgment on their practice.

We quickly realized that we could not effect change simply by requiring agencies and programs to implement a set of guiding tenets. We learned that even though we had a template for creating community-based standards of care, organizational infrastructure determined the speed at which movement could occur. We are responsible for making change happen, but we are also responsible for creating a safe, "holding environment" in which organizations can struggle and evolve without being penalized prematurely for not being "in compliance." ECC staff had to "hold and mold" at the same time. But this dual role taxed our internal capacity for providing technical assistance. Our solution was to hire outside organizations to help us with the "holding function" so that programs would be clear about ECC's role as molder (change agent). As change agents, we do not reside outside of the change process. Rather, we are changing as we respond to the needs of our funded organizations.

We are responsible for making change happen, but we are also responsible for creating a safe, "holding environment" in which organizations can struggle and evolve without being penalized prematurely for not being "in compliance."

We define the holding function as the ability to provide organizational support, technical assistance, training, and individual consultation to family support programs that are struggling to implement the model of enhanced service delivery that we require. To assist ECC Family Support Services staff and contractors in this work, we selected two local organizations: Through the Looking Glass and The Parent-Infant Program at Children's Hospital Oakland. Both used relationship-based approaches and had integrated models of care. These "holding organizations" offered small work groups on program structure, content, and process; reflective supervision groups for supervisors; and individual consultation support for administrators. In addition, some mental health staff became involved in a weekly infant mental health seminar (see Heffron, this issue, p. 47).

A Tale of Two Agencies

Vignettes of two ECC agencies illustrate the organizational processes associated with the integration of best-practice guidelines within their settings. Two programs in Alameda County provide services to the pregnant and parenting adolescent population. (Each year approximately 1,100 teens give birth in the county.) Both programs receive funding from the California Department of Maternal and Child Health and the State Department of Social Services. They provide case management services for pregnant and parenting teens and assist them with support and incentives to stay in school. ECC selected these programs as service contractors because the service delivery infrastructure already existed and we did not want to duplicate services. These programs also offered ECC an opportunity to leverage state funding streams. The best practice goals for the two agencies were: 1) integrating a child development component within the intervention approach; and 2) providing reflective supervision to help direct service staff use a relationship-based approach with program participants.

The larger of the two organizations had a long-term, grassroots-oriented organizational infrastructure. Staff had worked in the program for many years. The smaller organization was clinic-based. Before becoming involved with ECC,

this agency had begun a process of change and had recently hired many new staff members. It was easier for the smaller agency to make the changes required to implement family support best practices because there was less resistance to change in the organization. Everyone was new. Everyone was helping to build the service delivery model together. The larger organization, which operated programs in two counties, was more hierarchical. Staff were invested in homeostasis—keeping things operating in the "known zone." The larger organization was more resistant to a process of change initiated from the outside. As staff reorganized to accommodate change, ECC staff could hear and gauge the level of disequilibrium in the organization by the type of issues that arose and the type of clarification that was necessary.

Each agency struggled with different aspects of the model at different points in the change process. For example, the programs made very different choices about how to integrate annual developmental monitoring of children into their service model. The larger program used a centralized consultation model that had developmental screens scored and reviewed by a child development specialist. The smaller organization used a staff–family partnership approach in which staff performed and scored the developmental screen. Consultation was sought only if parents or staff had concerns. Each approach had implications for how staff worked with families.

Both programs established teams, whose supervisors began to hold weekly case conferences. Administrative staff of the larger organization recently reported that staff reflection on their process with families (a result of integrating best practice guidelines) had created a noticeable shift in how staff think about what they do and how they articulate their experiences to supervisors. Supervisors are learning to think about content (programmatic issues) and process (how it feels) when they work with early intervention staff. In thinking about the past 3 years, they stated the process of change would have been easier with more attention to the organizational context of relationship-focused work.

The Organizational Context of Change

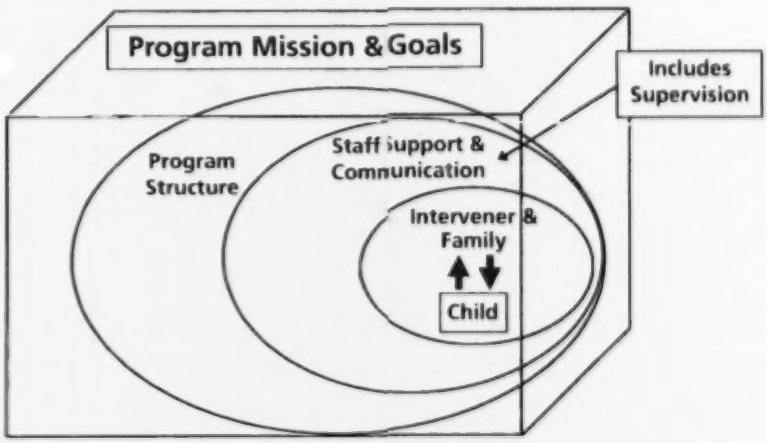
Helping programs formulate the centrality of relationship-based work from an organizational perspective is complicated and impacts all levels of organizational functioning (Weston, Ivins, Heffron, & Sweet, 1997). Figure 3 illustrates the levels of organizational infrastructure that are affected by the implementation of relationship-based processes.

Through its program goals, structure, staff support mechanisms, and communication, the organization itself is the holding environment for family–provider relationships. To effect change at the intervener and family level, the rest of the organizational infrastructure must examine how change at one level of the organization will inevitably impact other levels in the organization. External change agents (e.g., ECC, foundations, and other funders) must understand how to support the process of change. We must be sensitive enough to gauge when too much change is debilitating for an organization; we must develop shared problem-solving mechanisms.

ECC Family Support Services administrative staff use consistent, ongoing training and consultation (in conjunction with on-site, face-to-face technical assistance) to help

FIGURE 3:

Organizational Context of Relationship-Focused Work



programs implement the six best practice tenets. Reflecting on the process as it unfolds is also a powerful tool. ECC staff are now more sensitive to what constitutes "too much change all at once" and how much change organizations and staff can handle without causing major deterioration of program functioning. Change is slow and incremental. At times, it may be imperceptible, but it is real nevertheless. As change agents, we must listen for how change sounds and feels, not just how it appears.

Conclusion: Lessons Learned

ECC began with a charge to develop community-based standards of care for agencies and programs serving families and young children from birth to age 5. The strategic planning process created an environment of partnership and collaboration among staff, service providers, parents, and the general public. Within this environment, we defined an accountability framework that was grounded in a shared vision of what we wanted to accomplish as a community. ECChange became the tool that allowed us to create a common language across systems, organizations, and communities. The best-practice guidelines and evidence-based intervention strategies—all theory-driven—helped to further define the path to our goals. The most significant component of change is the process—the baby steps that move us forward.

We learned that collaboration means compromise. Providing funds to support change is not enough to make change occur. An organization that strives to be an agent of community change must be willing to accept community service programs as they are. We must "hold" programs while they are in a state of disequilibrium. We must help them explore their organizational culture and how it may impede their change process.

We learned that change is slow and, at times, imperceptible. To move forward, it is essential to keep figuring out how to create a community holding environment that is safe, allows for disagreement and compromise, and reinforces a continued commitment to envision what an integrated service delivery system should look like in our community.

We have learned that we cannot take a "one size fits all" approach to organizational change, but instead must look for organizational strengths and areas of concern in order to individualize organizational interventions. There must also be a willingness on the part of organizations to build trust with each other. In California, Prop 10 created an opportunity for communities to think together about how to create family-friendly environments on behalf of families with young children. It is early in the process, but we are already reflecting on how our communities are changing.

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Evaluating the Impact of Infant and Early Childhood Mental Health Training on Community Agencies

Mary Claire Heffron
Children's Hospital, Oakland, California

We had a new program—designed to improve mental health competencies among professionals who served very young children and their families—and a mandate to assess its effectiveness. We did not have a well-planned evaluation component, external funding, an outside evaluator, or even a consultant. Equipped with a sense of curiosity about whether we were reaching our goals, which included changes in the skills and knowledge of individual clinicians and changes in community programs, we began our fledging evaluation efforts.

In 2000, Children's Hospital and Research Center in Oakland began an Infant Mental Health Case Discussion Seminar on an experimental basis. Using money from a state-funded initiative designed to promote infant, family, and preschool mental health, we responded to a local shortage of infant mental health clinicians who were able to provide treatment and serve as consultants in preventive intervention programs. Beginning this effort was urgent because many new programs had been funded in our county by Proposition 10 (cigarette tax) funds and the need for trained staff was pressing. We proposed to see what would happen when we brought together clinicians who were interested in learning more about infant and early childhood mental health and who, in some cases, were already providing some services.

We provided weekly 2-hour seminars in which we discussed cases, provided reading materials, and became a resource for trainees, informing them about related conferences, training and print materials. We also set up weekly supervision using our team of clinical supervisors. All 5 of these clinicians were seasoned, licensed mental health clinicians. All had delivered infant–family and

at a glance

- To respond to a local shortage of infant mental health clinicians, we offered mental health professionals clinical seminars, reading materials, links to resources, and supervision.
- We wanted to encourage redesign of organizational structures to support new infant mental health services.
- Formative evaluations allowed us to adjust our training to the needs of trainees.
- Feedback from trainees prompted us to include more consultation and support around agency issues, as well as consultation and support groups around case material.

early childhood mental health services in a variety of programs and settings. Four were from our early childhood mental health program at Children's Hospital, and 1 of the supervisors was working with another agency, Every Child Counts, which was a partner in the development of the program. All had extensive experience in supervision.

Our goals were reflected in the following questions: First, could we increase the numbers of licensed clinicians who were able to provide infant mental health treatment and consultation in diverse and non-traditional settings? Second, would our training allow clinicians who were experienced in other fields to build competencies in infant–family and early childhood mental health? Third, could we make an impact on the trainees' agencies by increasing interest in serving infants and younger children and by encouraging a redesign of organizational structures within their agencies to support these new services or ways of practicing?

The main focus of this article is our evaluation of goal number three: agency impact. However, we begin with a brief description of our evaluation efforts for goals one and two to provide a context for our emphasis on agency impact. Also included is a summary of our efforts at formative evaluation that shaped how our program was developed, particularly in year one.

Our training program, now known as The Infant Family and Preschool Mental Health Training Program, is in its third year and has served 57 individuals and 20 programs since it began in August 2000. The trainees were diverse in their professional and personal backgrounds and included 6 individuals who were bilingual in Spanish, 1 who was bilingual in Farsi and serves the Afghani community, and 4 African-American clinicians. The participating agencies included public health nursing groups, teen parenting programs, child care mental health consultation programs, and a wide range of mental health agencies. These numbers indicate that we are making progress toward the goal of increasing the depth of the infant family mental health talent pool.

In year two, we began to keep accurate records of infants and children served by trainees and found that 144 young children and families received direct individual mental health services from trainees during the reporting period, with a growing number being served through a variety of consultation models. In a current tally done in December 2002, we calculated that first and second year trainees were seeing a total of 324 children in individual work. Of these, 319 children were involved in programs in which a trainee was a mental health consultant, and 8 trainees were involved in supervising other interns or staff.

We are making progress toward the goal of increasing the depth of the infant–family mental health pool.

In the beginning, we evaluated the experience of our participating trainees early and often using assessment questionnaires and supervision time to attempt to understand the usefulness of what we were providing. After administering the evaluation questionnaire, we used seminar time to obtain additional feedback from trainees. We let our pioneering trainees know that we wanted them to help us learn the ways of teaching and training that would help them become more skilled in working with the birth to 5 age group. We also acknowledged that they worked in many settings with specialized populations and that they already had skills that could be adapted to work with younger clients and their families.

In the first year, we quickly discovered through our formative evaluation efforts that although case discussion was useful and interesting, this group wanted a more didactic approach. We made adjustments by the second semester of the first year to create more structure. By the summer of 2001 we had further adjusted our program, creating an even more organized and stepwise introduction to the field of infant and early childhood mental health, assessment, and intervention techniques. We continued to use case discussion and an emphasis on clinical processes, but with more focus on principles and techniques that had been presented, discussed, and read previously. By 2002, we had gained additional clarity for our seminar through findings from our evaluation and from additional experience implementing the training program. We were able to articulate the training content with more precision for prospective participants. We also decided that it was important for our team to offer consultation to agencies at the request of trainees, because many were involved in trying to figure out how to integrate new ways of practicing into existing agency structures.

The evaluation of the responses of our trainee clinicians to the content and form of seminars and supervision was thus a relatively straightforward process. We designed questionnaires, scheduled time in our seminars for open discussion, and encouraged feedback and evaluation during individual supervision time. We came to know the trainees well. Gradually, as we learned how to adjust the training content and processes to trainees' learning needs, the trainees began to trust our willingness to listen and respond to them.

Although we believed that we were collecting accurate and useful information about the training and supervision experience, we knew from the outset that we faced a major challenge related to the assessment of professionals' skills and competencies. Although we tried to use questionnaires in our first year to identify baseline skills, competencies, and related experiences, we found that these questionnaires

did not yield very useful information. We realized that many of our trainees did not have a clear idea of how to respond to the questions, because they had very little exposure to the infant–family field. To address this challenge, we began work on developing an instrument that could be used to assess changes in the trainees' competencies and skills over time.

By the end of our first 9 months of the training program, we were pleased with the enthusiasm of the trainees. The learning curves were steep for many of the participants, but, in general, this was accompanied by a sense of satisfaction about working with infants and younger children. We found ourselves wanting to know more about agency impact. This led to the development of another questionnaire that served as an outline for an interview that would allow us to gather qualitative data on these matters. We went out into the community and interviewed the directors or program administrators who had sponsored each trainee. In most cases, trainees sat in on these interviews, often expanding the information and understanding of the directors and, in some cases, creating open dialogues about changing agency direction.

The learning curves were steep for many of the participants, but, in general, this was accompanied by a sense of satisfaction about working with infants and younger children.

The questions we asked during the agency impact component are listed in bold and a summary of the preliminary findings is included under each one.

1. This year a staff person(s) from your agency has participated in the Infant Mental Health Case Discussion Seminar. Please describe what changes you have seen in the staff participating in terms of

a) Increased focus on children 0–5 and their families

b) Increased skill in working with this population

c) Influence on other staff members who had not attended the seminar.

In the first year, several of the original 13 agencies reported that participating clinicians were more knowledgeable and articulate about infants and young children than they had been before their participation in the program. We heard about many instances of training materials influencing program practices such as adaptation of seminar case protocols and replication of seminar presentations and activities in local agency training efforts. Many agencies felt that they were already focused on this age group, but that the increased knowledge and resources of the participants were important and expanded interest in infant mental health services. In addition, we found that the seminar participation had created interest in dyadic treatment for toddlers and preschoolers, which differed from the individual therapy commonly used in general practice.

Strengthening of staff capacities in a direct job-related manner was a frequent theme in the interview. One administrator of a social services agency said that the new skills and knowledge were influencing others because the participant (a supervisor) was better able to help the agency make decisions about some of the difficult social service issues such as reunification and visitation.

Administrators of several agencies noted changes in service delivery approaches. For example, one teen-parenting agency adopted a more relationship-focused approach that included an emphasis on the developing relationships between mothers and babies. Although the agency's funders had requested this change in focus, the administrator felt that the knowledge gained from the seminar helped the agency operationalize this new way of doing business. One agency administrator acknowledged that, prior to the training, his agency had never really paid much attention to children under age 5, but now they were beginning to do so with regularity.

2. Participating agencies were asked if the time and financial commitment had been worthwhile.

All of the agencies surveyed reported that the commitment was worthwhile. Seven of those surveyed were very enthusiastic. However, four of the agencies mentioned that the time taken for the seminar and the supervision, although worthwhile, did at times interfere with other scheduled activities. We also found out that, for some agencies, the lost revenue that seminar and supervision time caused was a problem, and that our efforts to find stipends for these agencies had been appreciated.

3. Participating agencies were asked if structural changes had resulted from the staff person's participation.

A number of very specific structural changes indicated that agencies were considering how new ideas could be integrated into existing program structures. These changes included finding additional funding, hiring staff, and seeking more referrals for younger children. Some programs reconceptualized what they did and how they did it. For example, one agency hired a staff person to work in a new program to provide clinical services in a preschool setting. Another agency discussed how the seminar had influenced parent education programs they provided. This agency was also beginning to expand services to move from a child abuse focus to a more preventive intervention focus that included services targeting younger children. Other agencies reported new programs and practices, including a new home visiting program and a support group for families in which young children were included. Some of the interviews yielded information about structural barriers to expansion in the infant–family field. For example, a program supervisor reported that the program had been immensely valuable to his participating staff member. At the same time, he found that the pressure to serve school-age children was so great that he did not see how he could

accommodate the need to serve younger children without an infusion of new resources.

Summary

Our discussion of the impact evaluation of this training experiment, which grew into a program, must begin by acknowledging the limitations of our overall evaluation efforts. Because of limited funding, we lacked systematic baseline data about the trainees, we had no comparison group, and initially, we did not have the resources or the understanding to develop an instrument that could measure changes in the competencies, knowledge, and skills of our trainee clinicians. During our first year, we were so consumed with finding out what worked in terms of instruction, supervision, and agency relationships, that we omitted collecting data on the kinds of cases and program activities in which the participants were engaged. Subsequently, we have designed an instrument to measure baseline competencies and have also developed better mechanisms for collecting basic demographic information such as numbers of children served by seminar trainees.

Despite extremely limited resources for evaluation, at the end of our first year we decided to gather qualitative data about the impact of the training seminar on agencies that sponsored each trainee. Our efforts have led to new insights about how our training may have helped to create a shift in the thinking about the importance of clinical work with younger children and families. The interviews conducted with administrators as part of the evaluation also helped us build positive relationships with the agencies involved in the training program.

Our evaluation has allowed us to examine emerging needs and respond thoughtfully. For example, we knew there was a real shortage of supervisors, consultants, and specialists, but we had no idea how quickly program trainees would be recruited into service supervising and teaching others. This finding and feedback from our trainees prompted us to include more consultation and support around agency issues as well as ongoing consultation and support groups around case and program material.

In retrospect, we would have benefited enormously from a community or university partnership to assist in design and implementation of the evaluation. Carrying out our own evaluation helped us learn a great deal about our program's impact and the home turf on which our trainees operated, but having evaluators who were not involved in implementing the program would undoubtedly have been an asset. We will seek such help in the future as we continue to try to understand the impact of this training program on professionals' competencies and skills as well as on mental health agencies and communities.

SALLY PROVENCE AWARD FOR EXCELLENCE

* Recognizes, in alternate years, individuals and service programs whose work with infants, toddlers, families, and communities demonstrates the qualities that Dr. Provence considered essential to effective practice.

* Honors Sally Provence, M.D., a pioneer in the infant–family field and a founding member and president of ZERO TO THREE. As a pediatrician and mental health clinician at the Yale Child Study Center, she called attention to qualities in both individuals and programs that are likely to lead to success in supporting the development of very young children:

- an abiding curiosity about the meaning of behavior in very young children and their families;
- a sturdy conceptual framework for understanding developmental issues and problems in children and parents that also serves as the foundation for services;
- continuity and individualization of respectful care; and
- training and ongoing support for all professionals who touch the lives of babies, toddlers, and families.

ELIGIBILITY

The 2003 award will be made to an individual who meets the above-stated criteria.

NOMINATION PROCESS

Individuals can nominate themselves or be nominated by others. In the latter case, the nominator will determine the individual's willingness to be considered, and provide contact information.

SELECTION PROCESS

Individuals wishing to be considered for the award will complete an application that focuses on the way in which the four professional characteristics, above-mentioned, are brought to bear on services to children and families. The application, due September 15, 2003, includes questions for both the individual, professionals with whom the nominee works, and others served.

An Awards Committee will review all applications and notify applicants by October 15.

RECOGNITION

The award will be presented at the December 6, 2003, awards luncheon at ZERO TO THREE's National Training Institute in New Orleans, LA. Travel, hotel, and registration costs for the recipient will be complimentary. The recipient will also be featured in the *Zero To Three* Journal and on the organization's Website.

FOR MORE INFORMATION

For an application, please e-mail Bill McCall, Program Associate, at bmccall@zerotothree.org, or call him at (202) 638-1144, ext. 665.

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From Program Evaluation to Persuasive Reports

Sandra Smith
University of Washington Center for Health Education and Research
and
Judith Brown Clark
Michigan Family Independence Agency, Division of Community Support Services

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Written reports of program evaluations should clearly reflect the quality of your services. They should also help persuade funders and other decision makers to sustain support for your program. But most funders and decision makers scan reports and read selectively, even when material is complex. To make your report persuasive, you must make it easy to read. Joseph Pulitzer (Ireland, 1920) offered advice that can help program managers today:

> *Give it to them briefly so they will read it, clearly so they will appreciate it, picturesquely so they will remember it, and above all accurately so they will be guided by its light.*

Give it to them briefly

Too much information shrouds what funders want and need to know. Educated adults learn more faster from information that is brief and immediately applicable. So ask, What do I want my reader to *do* after reading this report? Then limit content to the critical minimum necessary to do that.

Brief means focused — Long-term behavioral and social changes, such as "school readiness for all 5-year-olds in the county," take a long time to achieve. Complex issues seem to require complex explanations. How can you accurately reflect your program's progress in a brief report?

Focus on positive outcomes that are appropriate to your program *now*. A first-year report might focus on implementation objectives — was the program implemented as planned? What administrative infrastructures did you establish? What referral processes did you set up? What collaborative relationships did you nurture? What staff have you hired and trained?

A second year report could focus on impacts — the early results of your program. For example, if you designed a client survey in Year 1, report results in Year 2 to demonstrate progress.

Only report outcomes that are directly associated with the program. Do not give detailed explanations of external influences. Rather, control for them statistically and mention to their combined effects briefly.

Brief means short — Write to inform, not to impress. Educated readers learn more faster from simply written information and prefer simple to complex writing. Choose short words in short sentences in short paragraphs. Require that every mark on the page earn its ink. For example, omit unnecessary preambles such as "It is important to note that…" Write for scanners. Review and summarize with bullet items.

Clearly so they will appreciate it

Adults learn by adding new information to what they already know. Information that ignores or conflicts with personal experience or cultural beliefs is subject to misinterpretation. Interview funders. They will frame the issues in their organizational culture and give you language that is familiar and clear to *them*. By listening you can discover how to formulate information that they can learn easily and quickly and that has the intended effect without adverse reactions.

To add clarity and increase appreciation for your program, take a positive tone. A negative sentence can seem hostile or bossy and discourage reading. A positive statement is inviting and encourages people to read on. Compare these sentences and note your feeling.

> *Many needy families do not engage community services that could assist them with their problems.*

> *The families we serve report that lack of information keeps them from using services they need and want.*

A simple declarative sentence (subject-verb-object) is the easiest way to process information. José Calderón (2002) of Drew University offers this hint to simplify complex writing. Look for FONBAYS — words that flag run-on sentences and need for a period: *for, or, nor, but, and, yet, so*. Compare your responses to two sentences:

> *Because counseling services to address the issue of domestic violence are important for battered women, this service is provided by many agencies.*

> *Ten agencies in King County offer services for battered women.*

Active voice brings information to life and clarifies

meaning. Personal pronouns (you, your) increase comprehension and speak directly to the reader.

By mid-July, proposals will be reviewed by the committee (passive, impersonal).

The committee will review your proposal by mid-July (active, personal).

Present tense and simple construction add immediacy and impact.

The new policy did not appear to be well understood by the home visitors, even though this group had primary responsibility for implementing it (past tense, complex construction).

Home visitors responsible for carrying out the policy may not fully understand it (present tense, simple construction).

Picturesquely so they will remember it — To give information color, texture, and meaning, choose words that that call up pictures in the reader's mind. Note what you see in your mind's eye as you read these descriptions.

A low-birth-weight baby is one that weighs less than 2500 grams.

Picture a baby the size of a banana. You can hold her in your palm.

Both examples present the same information in 18 syllables, but the second one is more picturesque, less technical, easier to understand, and so more informative. When you are unsure what words to use, ask the readers.

Picturesque means attractive — The *appearance* of your document, by itself, speaks for you and about you, accurately or not. Good document design attracts attention, conveys value, and guides the eye.

Aid scanning — Since busy readers scan and read selectively, use a simple predictable layout to guide the reader through your report. A table of contents directs readers to what matters to them. Bold type draws the eye to "road signs" — headlines and subheads that facilitate scanning. Italic type emphasizes key phrases or unfamiliar terms. Boxes, shading, bullets, simple graphics, and captions summarize and highlight key messages.

Type style and size — We read and make meaning from the shapes of words. Words in all-capital-letters are rectangles that require reading one letter at a time; so use upper and lower case in the title and throughout the document. Combining more than three fonts on the same page confuses the eye; so choose a solid plain font and stick to it. Minimum size for text you want someone to read is 10 point. Rather than reducing type size to fit more text on the page, look for ways to shorten the text.

Accurately so they will be guided by its light

A simple review process is inexpensive and worth the time to ensure that your report accurately reflects your good work and the quality of your services. First, review by an evaluator confirms your interpretation of the data and the scientific facts. Then, reading by a few "friendly outsiders" can uncover possible misinterpretations and suggest remedies. Ask your readers, What is the report asking you to do? What is missing? What should we omit? Where did you get lost?

By heeding Pulitzer's call for brief, clear, picturesque, accurate writing, you can deliver an evaluation report that helps funders and decision makers understand and value your program. ♦

Brevity Checklist

- ❑ Focus on positive outcomes directly associated with the program
- ❑ Most words have one or two syllables
- ❑ Sentences contain one thought, less than 25 words for skilled readers
- ❑ Paragraphs contain one idea, three to five sentences
- ❑ Lists contain no more than five items under one subhead

Clarity Checklist

- ❑ Text sounds conversational and personal; uses present tense, active voice and personal pronouns.
- ❑ Familiar language replaces or explains jargon.
- ❑ New information builds on what the learner already knows.
- ❑ Summarize and review

Picturesque Checklist

- ❑ Words that help the reader "see" what you mean replace or explain technical terms
- ❑ Interior layout is predictable, easy to follow
- ❑ Type and graphics guide the eye to key messages and aid scanning

Accuracy Checklist

- ❑ Content experts confirm scientific accuracy
- ❑ Reviewers confirm they understand the information the same way you and the experts do

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EVIDENCE-BASED PROGRAM EVALUATION:

A Guide for Agencies to Self-Assess Their Practices and Policies

DIANE HAMMON KELLEGREW
Associate Clinical Professor
Department of Occupational Science and Occupational Therapy
University of Southern California, Los Angeles, CA

SUSAN O'BRIEN
Director of Newborn Care, Boston Medical Center Birth Place
Assistant Professor of Pediatrics, Boston University School of Medicine

ELAINE GROPPENBACHER
Former Director of Clinical Services, Southwest Human Development Good Fit Center
Phoenix, Arizona

The genesis of our quest—the development of a guide for program evaluation that would be useful to program administrators—began during a ZERO TO THREE Leadership Development Initiative meeting in our first year as ZERO TO THREE Fellows. All of us agreed that evaluating a service program is a critical part of the administrative self-reflection process. Program evaluations can identify and sustain effective and cost-effective practice. However, the academicians and practitioners among us differed markedly in our emotional responses to program evaluation. The academicians in the group engaged in spirited debate, enthusiastically discussing the nuances of data collection and analysis that are part of program evaluation. In stark contrast, the practitioners and administrators among us talked about how intimidated—and therefore reluctant—we feel when we think about designing and implementing evaluations of our programs on our own,even though we want our programs to improve.

As a result of these discussions, we challenged ourselves to develop a program evaluation guide that could be employed by a program administrator without the support of research experts. The evaluation structure is relevant to administrators from a wide variety of disciplines and for evaluating a wide

at a glance

- An agency-initiated small-scale, strategic program evaluation can examine issues unique to a particular setting.
- Following selection of an evaluation topic, the three phases of program self-assessment are: 1) establishing goals and observable objectives; 2) data collection; and 3) data analysis and application.
- Our evidence-based program evaluation guide has been field tested by graduate students and practitioners in diverse settings.
- Assessment of one's work can be an embedded and ongoing part of an organization's structure.

variety of topics. Our guide is specifically designed to support the strategic analysis of one area of interest, concern, or innovation within a practice setting.

Toward a Small-Scale, Strategic Approach to Program Evaluation

Our underlying premise is that assessment of one's work can be an embedded and ongoing part of an organization's structure. Some business models also use this strategy as a method of continuous quality management (Green & McAllister, 1998). However, these business models are often management-driven and may not use outcome measures specific to any particular aspect of an agency's practice. We view program evaluation as a recursive process, much the same way that one evaluates, intervenes, and then re-evaluates a child and family. An effective program establishes a course of action, embeds program evaluation measures, and then periodically evaluates the impact of the course of action. This model is in keeping with the current evidence-based practice movement that promotes evaluating outcomes that matter—such as the campaign in children mental health services to "make success operationalized" (Worthington, Hernandez, Friedman, & Uzzell, 2001, p. 49).

The concept of embedded and ongoing program evaluation differs from the high-stakes monitoring efforts conducted by governmental and licensing agencies. Because of the nature of state and federal oversight, most agencies that serve children and families are part of high-stakes monitoring at some time. High-stakes audits aggregate the information collected across several sites. The data selected for collection are typically consistent across all sites and are not individualized for any one site that may be included in the monitoring visit. An example of a high-stakes audit is the monitoring of early intervention centers, reviewed as part of federal monitoring of Part C of the Individuals with Disabilities Education Act (IDEA). In such an audit, the primary purpose of collecting data at any one early intervention center is to gather a composite profile, from multiple centers, that represents the early intervention practices of a given state or region. The purpose is not to assess the practices of any one setting. Thus, this type of measurement is not an effective form of self-assessment for one agency.

Agencies that serve infants, toddlers, and families should initiate program evaluation efforts above and beyond the collection of data needed for mandated monitoring. This is expected in the changing culture of accountability. More and more, agencies are asked to provide evidence of internal program evaluation efforts and to document data-driven decision-making (State Interagency Coordinating Council on Early Intervention, 2002). This documentation is, in essence, a form of program self-assessment. In some cases, individual agencies can use their own evaluation findings to help shape the nature and content of larger-scale audits. For example, in California, early intervention services in three counties will be ranked side-by-side with other programs on measures of interest to families. This consumer guide will be given to new families as a tool to select services. Programs that have developed useful evaluation measures are being asked to assist in shaping the content of the guide (personal communication, Ami Sullivan, Xenologic Corporation, November 15, 2002).

In the process of refining our evidence-based program evaluation guide, we became increasingly committed to promoting a small-scale, strategic approach to program evaluation (Lamb, Donaldson, & Kellogg, 1998). Most program evaluation texts and literature discuss larger-scale monitoring processes (Ovretveit, 1998) that require resources and expertise not typically available in smaller programs for infants, toddlers, and their families. Small-scale program evaluation efforts that are likely to be useful to individual agencies are usually process-oriented. They examine the nature of service delivery and intervention that is idiosyncratic to a particular setting (Barnard, 1998). Agency-initiated program evaluation can best incorporate the unique and specialized issues confronting the children and families served in that setting.

The Relationship Between Evidence-Based Practice and Program Evaluation

Our program evaluation guide takes into account the movement toward evidence-based practice, which can be defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71). Traditional evidence-based practice revolves around a problem experienced by a client, the client's family, or both. The evidence-based practitioner seeks current best research literature that provides information about the specific clinical problem. The practitioner uses this information as part of the reasoning process when contemplating a course of action. Research evidence is one part of a complex decision-making process. It does not replace clinical experience and expertise or the desires and needs of the child and family (Law, 2002).

Historically, evidence-based practice has been used primarily by individual practitioners seeking to best address the concerns and care of individual clients. We advocate that agencies conduct an evidence-based inquiry of an area of interest prior to establishing an agency practice, using current best research evidence to inform agency practices.

Elaine Groppenbacher was Clinical Director of the Southwest Human Development Good Fit Center, an infant mental health agency in Arizona. She was concerned because mothers with mental illness seemed to be missing a large proportion of their appointments. Missed appointments can contribute to poorer mother and family outcomes, because of inconsistency in services, as well as less efficient use of staff time. The agency conducted an evidence-based inquiry to determine if research indicated more efficient or effective ways to deal with

this challenge. Staff found the most useful evidence in a systematic review of studies that described prompts to encourage people with serious illness to keep their medical appointments (Reda & Makhoul, 2003). The research studies included in the review employed text-based strategies, electronic reminders, telephone calls, personal visits, and financial incentives. An analysis of the research indicated that the simple strategy of sending an "orientation" letter 1 to 2 days before the appointment was most effective in reducing missed appointments. Groppenbacher used this information to adapt her agency's policies toward scheduling appointments for mothers with mental illness. The next step in the process would be to conduct an evidence-based program evaluation of the impact of the agency's policies on the appointment attendance of mothers with mental illness.

As this example illustrates, we recommend first designing agency policies and practices that reflect recommended practice (Gomm, 2000) using current, best research evidence. The next step is to then evaluate the effectiveness of those efforts using data-based outcome measures. In this way, research evidence develops the implementation and structure of an agency's program, and outcome data serves as evidence of the program's efficacy. We call this an evidence-based approach to program evaluation. The following sections describe the process and guide we developed for planning and implementing evidence-based program evaluation.

Development of the Evidence-Based Program Evaluation Guide

The first author of this article, Diane Hamman Kellegrew, agreed to take the lead in establishing a working template for small-scale strategic program evaluations. The ideas were originally tested in graduate-level courses for occupational therapy students enrolled at the University of Southern California. The working guide was field-tested by approximately 250 students, representing three different cohorts. The occupational therapy students developed program evaluation plans for a wide variety of clinical settings that served children at risk. The steps of the guide were refined based on the students' field experiences.

The program evaluation algorithm was then implemented and further refined in collaboration with the second and third authors, who are practitioners and administrators from different professional disciplines and practice settings. This step was essential. We knew that graduate students could successfully implement the steps when immersed in rigorous semester-long coursework, but we wondered if busy administrators with an interest in program evaluation could replicate the students' successes with more limited time and staff resources. Groppenbacher used the guide at Southwest Human Development Good Fit Center. Sue O'Brien, M.D., field-tested the guide as part of her duties as Medical Director of Newborn Care for the Boston Medical Center Birth Place. O'Brien is responsible for designing the learning experiences of the pediatric residents assigned to the Birthing Center and Newborn Nursery rotation.

Establishing an Evaluation Topic

Before beginning a strategic program evaluation, administrators must first identify the practice or program issue of interest. A program evaluation effort might center on an administrative issue, such as the scheduling of home visits with mothers who are mentally ill. Intervention-oriented concerns can also be appropriate for program evaluation. For example, a program evaluation might ask whether the use of sensory-oriented self-regulation strategies helps families at the agency to promote better sleep patterns in infants with poor self-regulation.

Some agencies have developed intervention strategies that are potentially useful to a larger field of practitioners. Larger-scale dissemination of these interventions requires their refinement, which can be accomplished in part through careful and systematic examination of their different aspects.

Sue O'Brien and fellow physicians of the Boston Medical Center Birth Place were interested in evaluating the attitudes and practices of pediatric residents in the newborn nursery setting. Their objective was to move from the traditional medical approach to a more holistic, family-centered, and developmentally appropriate one.

At the beginning of the newborn–nursery rotation, pediatric residents learn to administer a structured behavioral newborn examination, the Clinical Neonatal Behavioral Assessment Scale (Nugent & Brazelton, 2002) referred to as the CLNBAS. Throughout the rotation, the pediatric residents are given opportunities to practice the behavioral newborn assessment and are expected to incorporate it in their routine clinical work with families. The pediatric residents also have written, oral, and demonstrative opportunities that can be used to explore how knowledge of newborn behavior can be used to engage parents.

The purpose of O'Brien's evaluation was to identify and strengthen successful elements of the training program. She and her associates expect that as these young physicians interact with other immediate staff members, the positive effects of a strengths-based developmental approach will permeate beyond the immediate target group of pediatric residents. It is hoped that this training approach can be refined to the point of replication at other pediatric resident training facilities.

Program evaluation for up-and-running agency activities ordinarily begins in the midst of an ongoing project. In some cases, agencies can employ program evaluation at the start of an effort, giving them baseline data later. For example, in Arizona, the 2001 Jason K. Settlement Agreement led to a statewide reconceptualization of behavioral health services for all Arizona citizens, including children and families. The new model identified 12 principles that focus on the family system. Southwest Human Development Good Fit Center was selected as one of two agencies in the state to test the model and serve in the first phase of a statewide effort. Although high-stakes program monitoring is a mandatory component of the new model, self-directed program evaluation is not. Groppenbacher, clinical director of the center, realized that her program had an opportunity to compile evidence to assess the novel practices and policies of the new state model.

Her agency's efforts could help shape the future of behavioral health services for children and families in Arizona.

Although Groppenbacher first considered evaluating the implementation of all 12 principles of the new statewide model, she realized that staff resources would not be able to sustain a program evaluation effort on all fronts. She selected one of the principles, "Services tailored to the child and family," (Arizona Department of Health Services & Arizona Health Care Cost Containment System [ADHS & AHCCCS], 2001, p. 6) to target for examination. Similarly, she selected only one strategy to evaluate: the use of flexible funding.

Flexible funding had been established as part of a "wrap-around" service that "allowed child and family teams to access items or services in a cost-effective way that may be needed to help meet unidentified goals" (ADHS & AHCCS, 2001, p. 23). This new pocket of funds would be monitored for adherence to "accounting principles." But a review of accounting principles alone was unlikely to give a complete picture of the ways in which access to flexible funds contributes to child and family outcomes. Groppenbacher designed an evidence-based program evaluation to provide a holistic picture of outcomes resulting from the new flexible funding policy.

Comparing O'Brien's and Groppenbacher's efforts reveals major differences in the purpose of their program evaluations. However, both practitioner/administrators used the evidence-based program evaluation guide described in this paper. The variation in purpose and implementation opportunities in these two settings illustrates some of the challenges and opportunities that staff encounter in program self-assessment. These become clearer as we look at the three phases of program self-assessment.

Phase One: Establishing Goals and Observable Objectives

Clarifying the goal of the evaluation effort is the first and most essential step of an evidence-based program evaluation. If you have already identified an agency activity of interest and ensured that the practices are in keeping with current best empirical evidence, then this step may appear simple. Yet the experience of hundreds of professionals who helped refine this model suggests that clarifying the goal of the program to be evaluated can indeed be the most challenging step. Moreover, these precursor activities alone do not ensure clarity in the goal to be evaluated. In our experience, practitioners have become adept at thinking of intervention and intended result as a single course of action. Because of this, the act of establishing the goal to be evaluated creates a challenge to critically distinguish variables that indicate successful change from program features that facilitate this change.

O'Brien's program evaluation effort targeted pediatric residents. O'Brien is committed to the use of the CLNBAS, the newborn behavioral assessment tool used at Boston Medical Center Birth Place. This tool is one strategy that pediatric residents can use to engage and communicate with parents. O'Brien feels that this method of teaching medical students sets the foundation for the new physicians' appreciation of strengths-based newborn and family care.

Initially, as her evidence-based program evaluation goal, O'Brien wrote, "Residents will learn to use the CLNBAS tool when evaluating newborns." However, when she thought more about it, she realized that teaching residents to use the CLNBAS tool is actually a strategy to help them understand and embrace developmentally appropriate practices more generally. O'Brien refined her evidence-based program evaluation goal to "The resident will recognize the advantage of a strengths-based approach to medical care over an approach that emphasizes deficits."

After clarifying the goal of the evidence-based program evaluation, identify observable objectives. Conceptualize the objectives as subsets of the goal that identify what is useful to know about the goal. Practitioners and administrators have found it useful to hypothesize about the possible impact of the intervention or program practice. For example, O'Brien decided that the measurable objective for her goal of promoting family-centered practices of pediatric residents would be "improvement using a strengths-based developmental approach as measured during observation of one CLNBAS assessment." However, as she considered the impact of reaching this objective with each resident, she realized that she also wanted to see evidence of a strengths-based attitude at other times. She added the objective, "Facilitate unsolicited statements indicating a strengths-based perspective during pediatric residents' exit interviews."

The objectives selected should also take into account changes one might want to see in all stakeholders impacted by the goal. The program evaluation goal of the Southwest Human Development Good Fit Center was to evaluate the impact of flexible funding on the outcomes of families served. The flexible funding program was new to the agency. During the initial stages of this new program policy, funds had been allotted for such diverse items as payment of rent, a child's bicycle, and a mother's vocational school tuition. But at the time of the evaluation, few families had used the funds, so patterns of use were not well understood.

As originally designed, the evaluation effort would have examined only the needs of the families that received the flexible funding benefit. However, after hypothesizing about the possible impact of this objective, Groppenbacher realized that the use of flexible funding was primarily dependent on the activities of her staff. She expanded the objectives to include staff activities such as, "Staff will make each family aware of flexible funding opportunities during the initial intake interview." Another objective was gathering data about patterns of flexible funding use, including items or services purchased and degree of difficulty in obtaining the check once funds were authorized. The comprehensive evaluation of this new activity—flexible funding—gave Groppenbacher the evidence she needed to make critical decisions about supporting or modifying the new funding policy.

Phase Two: Data Collection

Phase two of an evidence-based program evaluation involves deciding what type of data will be collected and developing a data collection plan. The kind of data you collect should provide the information you need to achieve the observable objective you have chosen.

Groppenbacher wanted to know how long it took for families to get a check once the treatment team had approved flexible funding. The choice of data to collect was obvious – the number of days that elapsed between the time staff requested a check and a family received it.

When considering what type of data to collect, remember that the cost of collecting the data should not outweigh the benefit of the knowledge you gain. Using naturally occurring opportunities to collect data makes it more likely that collecting data for program evaluation will become an ongoing agency routine.

The Southwest Human Development Good Fit Center already collected intake information during the initial interview with families referred for services. Groppenbacher determined at the onset of the program evaluation that her staff would not have time to handle an additional data collection procedure. Therefore, she made sure that data collection for her program evaluation required only minor modifications of pre-existing data collection procedures. The agency simply added questions on the intake form to identify whether or not a family had been made aware of the flexible funding policies and if the family had any flexible funding needs at the time of intake. This data collection format not only used naturally occurring data collection procedures but also made staff more aware of the new flexible funding policies.

A data collection plan should include guidelines for data collection procedures—the who, what, when, and where of data collection. Staff training may be necessary.

O'Brien quickly realized that she could not personally meet with the residents to conduct all the required CLNBAS assessments because she was not always on duty when an assessment needed to be performed. She recruited the newborn unit nurse practitioner to help monitor the progress of pediatric residents during the CLNBAS assessments. She created a checklist to identify family-centered behaviors that she wanted the residents to demonstrate in addition to the behaviors identified by the CLNBAS tool. The nurse practitioner and O'Brien began to share the responsibility for teaching the CLNBAS and gathering data.

Phase Three: Data Analysis and Application

In phase three, practitioners and administrators examine and interpret trends that are evident in the evaluation data and apply the new knowledge to the area of interest. In traditional evaluations, evaluators collect the data, analyze the data, and, lastly, reach a conclusion about the results. In the evidence-based program evaluation guide, however, we suggest collecting data for a preliminary analysis before you complete the program evaluation effort.

A preliminary data analysis effort may seem redundant. After all, you will need to analyze the data again when the program evaluation effort is over. But our field tests taught us that while many practitioners and administrators can visualize a goal, define objectives, and collect data, they tend to let data sit in computers and on desktops, unexamined, for long periods of time. Until you analyze the data you have collected, you cannot use the information to help shape the direction of your program or guide your efforts to improve it. When programs include preliminary data analysis as part of their ongoing program evaluation effort, however, data analysis proceeds quickly and relatively easily.

A preliminary data analysis plan should identify who will review the data, when they will do it, and where.

Groppenbacher summarized data on the use of flexible funding during each monthly staff meeting. Clerical staff kept a running tally of the information as each intake form was received, so aggregating the information each month was quite easy. This system for data analysis also allowed the agency to quickly identify month-by-month trends in the use of funding.

Frequently, evaluators must determine how much data is enough to identify a trend or pattern. The optimal length of the data collection phase of program evaluation depends on a complex interaction of factors. These include the amount of data gathered at one time, the homogeneity of the data, and the depth of data collected from any one source. The deeper the understanding of the topic of interest, the easier it is to establish enough of a trend to determine the need for changes in practice. For this reason, simple numeric data rarely gives a complete picture about a topic of interest. It is best to apply multiple measures to determine a trend or pattern.

O'Brien's experience illustrates this point. The Boston Medical Center Birth Place enrolls only one pediatric resident per month. The data O'Brien gathered to evaluate her objectives included answers to essay questions, several observations of the resident over the course of the month, and a qualitative interview with each resident following the month-long rotation. Given the depth of input from each resident, O'Brien might have been tempted to change the resident training program from month to month. However, information from one resident may not reflect the experiences of residents during the following months. O'Brien conducted a preliminary data analysis every 3 months. If the same patterns in the responses of three different residents, she felt confident in the trend and considered changing the structure of the rotation to better achieve her goal of promoting family-centered practices.

The Southwest Human Development Good Fit Center opted to conduct a preliminary data analysis on all measures used to analyze flexible funding after 6 months of data collection, although trends in flexible funding use were noted on a monthly basis. Regardless of monthly trends, the agency would not change practices before a 6-month period had elapsed. The flexible funding program was essentially a pilot; no one knew what to anticipate over time or how the program would ultimately be supported by the funding agency. Data about the use of the program, its benefits to families, and the challenges of monitoring and administrating

the funding program needed to be clearly and convincingly established. This type of longitudinal information would later help to justify long-term agency practices in this area.

Conclusion

The evidence-based program evaluation guide met our original purpose: The process can be used by a wide variety of agencies and professionals from different disciplines. Little background in formal program evaluation or research methods is needed to use the guide. The strategic, small-scale scope of our approach to program evaluation encouraged programs to find ways to examine the

Table 1: Evidence–based program evaluation guide

Evaluation Activity	Strategies for Success
Phase one: Establishing goals and observable objectives	
1. Clarify the goal of the program activity or intervention to be evaluated.	The goals of the activity should identify the desired outcome of the activity or intervention to be evaluated. The goal should be understandable to all who participate in the evaluation process.
2. Determine measurable objectives that address the goal.	The objectives should identify the desired outcomes of all stakeholders involved in the activity to be evaluated. Develop clear standards to determine if the objective has been met. Consider efficacy as well as cost-benefit objectives.
Phase two: Data collection	
3. Determine the type of data needed to comprehensively address the goal.	Use naturally occurring data collection opportunities for ease and maintenance of data collection. Consider both quantitative and qualitative measures.
4. Develop a data collection plan.	Identify who, what, when, where, and how data collection will occur. Implement staff training for data collection.
Phase three: Data analysis and application	
5. Design and implement preliminary data analysis.	Develop a plan to periodically aggregate, collect and review data before the end of the program evaluation period. Do not make changes as a result of this analysis, but be aware of trends.
6. Analyze data according to a pre-planned schedule.	End the program evaluation at a predetermined time when one would expect to see progress given the frequency and duration of the data collection plan. Analyze data from all angles, crosschecking assumptions using multiple data sources. Consider the implications from the perspective of different stakeholders. Does the program work for some but not for others?
7. Improve programs as needed.	Make adjustments to your program activity or intervention as needed. Begin new program evaluation efforts to reflect these changes.

practice policies and interventions that mattered most to their individual agencies.

Conducting ongoing evidence-based program evaluation efforts, embedded in the daily routines of the agency, encouraged most programs that participated in field tests of our model to think in a new way. The method required agencies to continuously evaluate established, routine practices. The model encouraged agencies to create a culture of continuous learning. Each intervention or agency practice was open for review and examination.

This process of program evaluation initially served to clarify the purpose and intended outcome of agency practices that may not have been fully examined before. In other words, the very process of examining a program element of interest led to a better understanding of the practice. Collecting data prompted a critical look at agencies' administrative policies. We found that each agency collected a mass of data. Some of the information was critical to the services provided, but few agencies used much of the data collected routinely from practitioners and families to support agency goals effectively. In some cases the data collected was important but not effectively analyzed or applied to improve practices. As a result of participation in the evidence-based program evaluation, many programs clarified their existing data collection procedures.

Despite the benefits of the evidence-based program evaluation, it would be inaccurate to report that all programs that participated in our field tests successfully completed all phases of this process. In many agencies, critical administrative and practice duties competed for valuable time and staff resources. Some agencies may need to make multiple attempts to incorporate new ways of thinking about effective practice into established administrative policies. Refer to Table 1 and the sidebar for more information.

Voices From the Field

"To date, we are still in the early stages of this program evaluation. Our goal is to use the data we gather to shape our curriculum in a way that is most effective for the learners [residents] and teachers [physicians and nurse practitioners]. Our over-arching goal is to frame the residents' understanding of a healthy patient-doctor relationship as one that focuses on strengths. Our work thus far has helped us see some of the real challenges that exist when one tries to conduct a clinical program evaluation in a very busy place. Time and competing urgencies are two of our biggest challenges. Our lessons learned as we move forward are to keep our program evaluations simple and to value every encounter as an opportunity to assess, no matter how brief."

Sue O'Brien, M.D., Medical Director of Newborn Care, Boston Medical Center Birth Place

Despite the challenges involved in program evaluation, recommended practice requires that agencies critically examine the efficacy of intervention and service delivery (Shonkoff & Phillips, 2000). A growing body of evidence addresses the outcomes of specific interventions and service delivery models for children and families. Agencies that seek to provide high quality services can use this information as part of data-based justification for a course of action. However, as any consumer of research can attest, there are gaps in the high-quality research evidence that addresses many important administrative and practice concerns. Professionals often need to rely on reasonable hypotheses to design well-intended intervention and policy in a world where clear-cut answers are not currently available (Fenichel, 2001). It is the responsibility of professionals to continue to seek the best solution to meet the needs of the children and families served. Strategic, evidence-based program evaluation efforts can foster increased program effectiveness, assisting administrators and practitioners to meet this challenge.

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POINT OF VIEW

EARLY HEAD START – AN INVESTMENT IN OUR YOUNGEST CITIZENS

U.S. SENATOR TOM HARKIN

Most Americans are very familiar with Head Start. This popular preschool program was created in 1965 to provide education, health, nutrition, and family support services to low-income, 4- and 5-year old children. Head Start enjoys strong bipartisan support and is widely recognized as a success.

In response to the growing body of research about the critical development, which occurs during the first 3 years of a child's life, Head Start was expanded in 1995 to serve infants and toddlers. The Early Head Start Program provides comprehensive child development and family support services to infants and toddlers from birth through age 3 and to pregnant women. Currently, 10% of Head Start funds are set aside for Early Head Start. An estimated 60,000 children currently receive services nationwide. In my own state of Iowa, 1,259 infants and toddlers are served by Early Head Start.

Numerous research findings, including a national evaluation, show that Early Head Start is a success. Early Head Start made positive impacts in children's cognitive, language and social–emotional development. Compared to a control group, parents in Early Head Start not only read to their children more often but also provided additional resources to support greater language and literacy development.

These outcomes for our nation's most vulnerable infants and toddlers are extremely promising, especially when we consider children's enormous potential and unlimited eagerness to learn during the critical early years. Recent research shows the impact of parents and other caregivers reading to babies and toddlers, talking with them, and stimulating learning through play. Children who do not have rich, pleasurable learning experiences during these important years miss opportunities that can never be fully recaptured. When babies and toddlers live in high-risk environments, their families need additional supports to help them foster their children's intellectual, social, and emotional development — the foundation for later success in school and life.

Early Head Start provides effective, targeted care for low-income infants and toddlers and encouragement supports for their parents. Yet 8 years after the establishment of Early Head Start, only 3% of eligible children are being served. On July 23, 2003, I introduced legislation that would double the number of participants by 2008 by increasing Early Head Start's share of the Head Start appropriation to 20%.

Investments in our youngest citizens must become a national priority. This is the right thing to do for the young children of our nation, and it is also the most cost-effective thing for us to do.

A dozen years ago, in 1991, the Committee for Economic Development (CED) urged federal policy makers to view education as a process that begins at birth, with preparations beginning before birth. I strongly support this objective and have always been a strong advocate for Head Start, the WIC nutrition program, and early intervention programs for infants and toddlers with disabilities.

We must dedicate ourselves to making the CED vision a reality by ensuring that all children get off to a good, strong start and enter school ready to learn. The legislation I introduced recognizes that all babies enter the *world* ready to learn. It brings us a step closer to the day when all young children have the opportunities and support they need to embark on a lifetime of learning.

Early Head Start Information Kit: Research to Practice Addendum

(2003) Prepared by the Early Head Start Research and Evaluation Project. Available from the Head Start Information and Publication Center, P.O. Box 26417, Alexandria, VA 22313-0417. Tel. 866-763-6481. Free of charge. Web site: www.HeadStartInfo.org/infocenter.htm.

Findings from the ***Early Head Start Research and Evaluation Project*** were released in a series of research reports. The final report, *Making a Difference in the Lives of Infants and Toddlers and Their Families: The Impacts of Early Head Start*, was released in June 2002. ***The Early Head Start Information Kit: Research to Practice Addendum*** was prepared to be used by staff, parents, trainers, community partners, government officials, and other interested stakeholders to disseminate the findings from the ***Project***. The ***Kit*** includes a 4-page research brief of the overall findings of the project, a CD-ROM with two PowerPoint presentations (long and short versions), and a Talking Points booklet to be used with the presentations. The ***Kit*** also includes special topic information on *Child Care* and *Depression in the Lives of Early Head Start Families*. For each topic there is a 4-page research brief, a CD-ROM with PowerPoint presentations, and a Talking Points booklet to be used with the presentations. Additional special topic information will be available in the near future.

KIDS COUNT Data Book

(2003) Anne E. Casey Foundation (701 St. Paul St., Baltimore, MD 21202; entire text available at www.kidscount.org) Free. Paperback.

The 14th annual KIDS COUNT Data Book reports the trends in child well-being over the past decade, on both national and state levels. The data book begins with an essay on "The High Cost of Being Poor," which claims that Americans living in poverty pay more to participate in the workforce, pay a paradoxically higher price for basic goods in their neighborhoods, and pay more for financial services due to isolation from non-predatory financial institutions.

Over the past 10 years, the Annie E. Casey foundation has gathered data on indicators of child well-being including the percentage of low-birthweight babies; infant mortality rate; child death rate; teen birth rate; percentage of children living in families where no parent has full-time, year-round employment; percentage of children in poverty; and percentage of families with children headed by a single parent.

Background information on each state includes demographic change, economic conditions of families, child health, education, and the use of federal poverty relief. Each state is ranked by its child well-being score in 2000, the last year from which data is available. The data book compares statistical data from 1990 and 2000, and uses bar charts to graphically demonstrate which indicators have changed for the better, and which for the worse, in each state. Appendices include the raw data and rankings for each year between 1990 and 2000.

Bonding with Baby Developmental Books, Series 1

(2002) Developing Hearts Systems, Stratford, Connecticut. To order, call 866-LAP-TIME or visit www.bondingwithbaby.org/order.asp for a printable order form. $20.00. Board.

This set of four interactive board books is designed for both literate and non-literate parents to share with their children under. Each book has a clear plot (conveyed in drawings featuring diverse families) but no words. An accompanying parent education video has been distributed to parents in 82 Healthy Families America sites and is available to infant–family service providers.

An evaluation of the impact of the *Bonding with Baby* books and video on families' book-sharing habits was conducted by Grover J. Whitehurst, formerly on the faculty of SUNY Stony Brook and currently with the US Department of Education. Findings showed that parents who received the books at intervals shared books of all kinds more frequently with their babies than parents in the second group. Parents who had received the books during the study also were much more likely to report that both they and their children enjoyed book sharing. A second evaluation of the Bonding with Babies intervention is underway.

Attachment Therapy on Trial: The Torture and Death of Candace Newmaker

(2003) Jean Mercer, Larry Sarner, and Linda Rosa, with a chapter by Gerard Costa. Child Psychology and Mental Health Series, Praeger Publishers, 88 Post Road West, Westport, CT 06881. www.greenwood.com. $44.95. Hardback.

Candace Newmaker, a 10-year-old from North Carolina, died in Colorado in April 2000 in the course of a treatment known as Attachment Therapy (AT) given her by two unlicensed social workers. She suffocated inside a tightly wrapped sheet while adults pressed their weight against her body. The authors of this volume (Mercer is President of the New Jersey Association for Infant Mental Health) describe AT as an unvalidated treatment and provide a number of "warning signals" that are typical of unvalidated or fringe treatments.

In a chapter describing how trained psychotherapists would have approached Candace, psychologist and infant mental health educator Gerard Costa describes principles of infant–parent relationships

and treatment. He also describes five major categories of helping, derived from work on infant mental health that can be used throughout childhood and adolescence. These are: 1) building an alliance, 2) concrete services, 3) developmental/parental guidance, 4) supportive counseling, and 5) dyadic (parent–child) psychotherapy.

Also of Interest:

Motherhood Lost: A Feminist Account of Pregnancy Loss in America *(2003), by Linda L. Layne (Routledge, 29 West 35th Street, New York, NY 10001, www.routledge-ny.com) Paperback. $24.95.* The author discusses the cultural basis of contemporary American views of pregnancy loss.

When the Brain Can't Hear: Unraveling the Mystery of Auditory Processing Disorder *(2002), by Teri James Bellis (Pocket Books, 1230 Avenue of the Americas, New York, NY 10020) Hardcover. $25.00.* The author discusses the nature of auditory processing disorder (difficulty comprehending spoken language) and the latest treatment options for this condition.

Like Sounds Through Water: A Mother's Journey Through Auditory Processing Disorder *(2002) by Karen J. Foli (Pocket Books, 1230 Avenue of the Americas, New York, NY 10020) Hardcover. $25.00.* The author presents an optimistic, first-hand account of her family's experience finding treatment for her young son with auditory processing disorder.

Anxious Parents: A History of Modern Childrearing in America *(2003) by Peter N. Stearns (New York University Press, Washington Square, New York, NY 10003, www.nyupress.org) Hardcover. $29.95.* Historian Stearns examines the shift toward "a worried picture of childrearing" beginning in the early 20th century, particularly the rising concerns of parents about their own ability to parent effectively.

On-line Resources

Pathways to Outcomes

www.PathwaysToOutcomes.org

The Pathways To Outcomes Web site offers information about "what works" (i.e., provides a pathway) to help children and families reach targeted outcomes. Currently, the site focuses on the Pathway to School Readiness, describing community efforts to ensure that **all children are ready for school** at the time of school entry. Pathways are products of the Pathways Mapping Initiative, directed by Lisbeth B. Schorr and developed in partnership with the Technical Assistance Resource Center of The Annie E. Casey Foundation. Each Pathway displays actions that contribute to the desired outcome, attributes of program effectiveness, and indicators that measure progress. Community planners, funders, policy makers, and service providers will also find statements of the rationale underlying particular courses of action and evidence of their effectiveness, as well as examples of programs that incorporate promising actions and attributes.

Planning for Success: Mapping Goals, Services, and Outcomes for Program Improvement (Birth to 5 Best Practices Issue No. 2)

www.OunceOfPrevention.org

This brief is one of a series produced by the Illinois Birth to Five Project to explore key issues of program quality and best practices within prevention programs serving families with young children. The Project is managed by the Ounce of Prevention Fund and supported by the Robert Wood Johnson Foundation and the Early Childhood Funders collaborative. *Planning for Success* describes the "logic model"—an explanation of why a program is providing a certain set of services to a particular population and the intended impact of those services. Elements include outcome goals, program services, process indicators, outcome indicators, and rationale. The brief offers guidelines for developing and using a logic model to improve program quality and describes several programs' use of a logic model.

Do You Believe in Magic? What We Can Expect from Early Childhood Intervention Programs

www.srcd.org/spr.html

This Social Policy Report from the Society for Research in Child Development presents a policy research brief that developmental psychologist Jeanne Brooks-Gunn presented to Congress, accompanied by commentary by Janet Currie, Robert N. Emde, and Edward Zigler. Brooks-Gunn observes that "the large effects seen at the end of early education are not due to magic; they are based on what is known about young children's development, and the conditions that promote or impede it....To expect effects to be sustained throughout childhood and adolescence, at their initial high levels, in the absence of continued high quality schooling, however, is to believe in magic (p. 3).

Effectiveness of Early Childhood Development Programs

www.TheCommunityGuide.org/social

The Task Force on Community Preventive Services, working under the auspices of the US Centers for Disease Prevention and Control, has released findings about the effectiveness of early childhood development programs against developmental delay in a supplement to the *American Journal of Preventive Medicine (AJPM)*. The Task

Force reviewed available literature on evidence of effectiveness (assessed by reductions in retention in grade and placement in special education) as part of a larger review of interventions designed to improve health through changes in the social environment. The Web site offers a summary of the Task Force review, as well as links to printable versions of the detailed evidence reviews published in the *AJPM*.

Commonwealth Fund Releases Report on Improving Health Services for Young Children

www.cmwf.org/programs/child/halfon_bridge_564.pdf

The Commonwealth Fund is a private foundation that supports independent research on health and social issues and makes grants to improve health care practice and policy. The May 2003 report entitled Building a *Bridge from Birth to School: Improving Developmental and Behavioral Health Services for Young Children* reviews existing guidelines for developmental care of young children from birth to their entry in school. It assesses the evidence for the effectiveness of providing such care in primary care settings.

Family Support America (FSA)

www.FamilySupportAmerica.org/publications

FSA works to place principles of family support practice in every setting in which children and families are present. One feature of the FSA Web site is information on **How Are We Doing? A Program Self-Assessment Toolkit**. This software is designed to help family support programs evaluate their performance in 10 different areas of operation, from governance to staff roles and capacities. A new CD-ROM version of the software can be used to create customized reports of a program's strengths and needs.

The Early Childhood Mental Health Project: Child Care Center Consultation in Action

www.jfcs.org

This manual describes key features of the Early Childhood Mental Health (CMH) consultation model that has been developed by Jewish Family and Children's Services in collaboration with Daycare Consultants/Infant Parent Project of the University of California, San Francisco and implemented at 46 child care sites. The manual outlines steps to be taken and systems to be developed if other organizations wish to start similar programs. An in-depth evaluation study of the program has been undertaken under the guidance of Sharon Lynn Kagan of Columbia and Yale Universities.

Ensuring Continued Success of Large-Scale Initiatives

www.UrbanHealth.org

This site describes conclusions from the seminar "Strategies To Ensure the Continued Success of Large-Scale Initiatives," part of the Urban Seminar Series directed by William Julius Wilson of Harvard University and funded by The Robert Wood Johnson Foundation. Seminar participants observe that politics ultimately determines the sustainability of large-scale initiatives but that leaders need to pay close attention to documenting successes in a rigorous way. Overstating results from weak or inconclusive research, however, can do more harm than good.

Program Evaluation by Innovation Network, Inc.

www.InnoNet.org

Innovation Network is a national nonprofit that builds the evaluation capacity of nonprofits and grantmakers. It provides consulting, training, and Web-based tools for nonprofit program planning and evaluation. The site features free downloads about designing and evaluating a program from their Evaluation Resource Center. The site is subdivided into four main categories: general guides, logic models, data collection, and data analysis.

GrantsAlert for Nonprofits

www.GrantsAlert.com/education.cfm

This site researches new funding opportunities for non-profit organizations, particularly those involved in improving education. The site's searchable database has an "*education*" icon that identifies corporations with grants available for early childhood education, at-risk children, and school readiness programs.

UWEX Release Study on Part C of IDEA

www.uwex.edu/ces/familyimpact/reports/fia3.pdf

The University of Wisconsin Extension (UWEX) works to apply university knowledge and resources to the current needs of families, professions, businesses and communities. "A Family Perspective on the Individuals with Disabilities Education Act," from the Policy Institute for Family Impact Seminars, looks at how well Part C of the IDEA helps young families and coordinates services.

CLASP Releases Policy Brief on Early Head Start Children

www.clasp.org/DMS/Documents/1056552655.59/EHS_brief3.pdf

The Center for Law and Social Policy (CLASP), a national, nonprofit organization founded in 1968, conducts research, policy analysis, technical assistance, and advocacy on issues related to economic security for low-income families with children. CLASP's June 2003 Policy Brief reports on Early Head Start with Head Start programs and associated benefits. It addresses the impact of EHS and the potential effects on eligible families of reauthorization.

Upcoming Issues

September 2003 – This issue will mark the 25th anniversary of ZERO TO THREE. Seasoned ZERO TO THREE Board members and colleagues who have entered the field more recently will discuss **major trends in infant–family theory, research, and practice**. Contributors include Carol Berman, Linda Eggbeer, Stanley Greenspan, Linda Gilkerson, Irving Harris, Robert Harmon, Ron Lally, Joan Lombardi, Cindy Oser, Jeree Pawl, Arnold Sameroff, Bernice Weissbourd, and Serena Wieder.

November 2003 – Graduate Fellow Joy Browne is the guest editor of this issue, which examines **new perspectives on prematurity**. Articles will describe recent developments in research and clinical practice, mental health issues related to prematurity, dilemmas in the care of premature babies, lessons learned from long-term follow-up, developments in public policy, and the experiences of parents and other family members.

January 2004 – The contributors to this issue will describe **what babies can teach those who take the time to engage with them fully** — for example, that children under age 2 are funny, that babies and toddlers have very complex emotions, and that babies "cut through the cover of everydayness." We will also learn what a group of Navajo women see when they observe babies, and how infants and toddlers in the classroom prepare children for parenting. Contributors will include Betty Bardige, Eleni Louizu, Vasudevi Reddy, William Schafer, Colwyn Trevarthen, Deborah Weatherston, and Barbara Wightman, among others.

The Editorial Mission of the *Zero to Three* Bulletin

To provide a forum for thoughtful discussion of important research, practice, professional development, and policy issues in the multidisciplinary infant, toddler, and family field.

The Mission of ZERO TO THREE: National Center for Infants, Toddlers, and Families

ZERO TO THREE is a national nonprofit whose mission is to promote the healthy social, emotional, and intellectual development of our nation's infants and toddlers by supporting and strengthening families, communities, and those who work on their behalf.

www.zerotothree.org

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ZERO TO THREE®

Suite 200
2000 M Street, NW
Washington, DC 20036-3307

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UNIV OF ILLINOIS @ CHAMPAIGN
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